

*San Francisco County
Preliminary Master Plan
1991-92*



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**SAN FRANCISCO
DRUG REBELLION**

San Francisco County Master Plan

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I.

Executive Summary



**SAN FRANCISCO
DRUG REBELLION**



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Executive Summary

Introduction

The City and County of San Francisco is similar to many other urban environments characterized by highly diverse communities residing in densely populated and geographically restricted areas. Measuring 47 square miles, San Francisco is estimated to have 741,300 residents (U.S. Census, July 1987 Estimates). The diversity of San Francisco's neighborhoods, the richness of its cultures and the magnitude of its substance abuse related problems has contributed to the complexity of developing a comprehensive continuum of care for all San Francisco residents.

While San Francisco accounts for only two and a half percent of California's 28 million inhabitants, it carries a disproportionately high rate of alcohol and other drug related incidents. These problems are compounded by an HIV infection rate that is the second highest per capita in the country, surpassed only by New York City; and a large homeless population with multiple diagnoses. Many of the County's neighborhoods have a significant population of high risk, multiple problem youth, most of whom are using drugs and/or are at immediate risk of beginning drug use.

While the County Master Plan applies to all neighborhoods, several specific communities have previously been identified in other planning efforts by the Health Department and the Mayor's Drug Symposium as being high impact areas. The planning process will continue to pay particular attention to the needs of these neighborhoods, which include: (1) the Western Addition; (2) the Tenderloin; (3) Potrero Hill; (4) the Mission District; (5) Bayview Hunters Point; (6) Visitacion Valley/Sunnydale; (7) the OMI (Oceanview-Merced-Ingleside); and 8) Chinatown. Although not geographically contiguous, these neighborhoods share many indicators of socioeconomic and health status problems including high numbers of low-income ethnic minorities, crowded substandard housing, unemployment, single-parent families, low-birthweight deliveries, and high rates of sexually transmitted diseases. A high incidence of substance abuse related problems is also shared by the members of these target neighborhoods, such as crack-cocaine use, gang-related violence, drug-related arrests, child abuse and neglect referrals, cocaine-affected births, arrests for narcotics violations and homelessness. Additionally, access to existing drug treatment services is inadequate, as measured by an average waiting period of three months for entry into services.

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Community Substance Abuse Services

The mission of Community Substance Abuse Services (CSAS) is to reduce the overall consequences of alcohol other drug abuse in San Francisco by assessing needs, setting goals, identifying priorities, implementing and evaluating programs. CSAS is committed to providing quality alcohol and other drug prevention, intervention, treatment, and aftercare services to anyone who, for financial or other reasons, is denied services in the private pay sector. As part of the Division of Mental Health, Substance Abuse and Forensic Services (DMSF), CSAS plans and develops a continuum of care guided by three principals: 1) Consumer guided, 2) Community based, and 3) Culturally competent.

The Master Planning to Reduce Alcohol and Drug Problems

The primary goal of San Francisco's Master Plan as defined by Senate Bill 2599, is to establish a community partnership for the reduction of alcohol and other drug related problems. To meet this goal, CSAS will implement the following six objectives:

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1. Establish a system and network of interagency agreements, Memorandums of Understanding and collaborative communications to initiate and implement an effective planning process.
2. Establish an inter-disciplinary, multi-cultural and community-oriented County Master Planning Advisory Body.
3. Conduct a comprehensive needs assessment of services, needs, gaps, utilization and trends related to alcohol and drug use and abuse in San Francisco.
4. Enhance and sustain a strategic planning effort which assures the identification of action steps and the implementation of planning objectives.
5. Establish a system of information sharing which is responsive to local requests and needs as well as requirements of the State Department of Alcohol and Drug Programs.
6. Prepare a comprehensive County Master Plan to Reduce Alcohol and Drug Problems in San Francisco.

The Master Plan process builds on considerable local effort to assess problems, identify gaps, and attack the issues of drug and alcohol abuse, and their related problems in San Francisco. The leadership and key participants necessary to complete this comprehensive systems approach have already been convened through various ongoing planning efforts, including the Mayor's Drug Symposium Task Force, Homeless Task Force, Criminal Justice Administrators Group, the Planning Advisory Group of the Division of Mental Health, Substance Abuse and Forensic Services, the Citywide Alcoholism Advisory Board, the Drug Abuse Advisory Board, the AIDS and HIV Task Force and others.

Master planning activities began with the development of a database that includes over 1500 concerned individuals and organizations, from which the eighty current members of the Master Plan Advisory Body were appointed. More than a dozen committees and task forces in San Francisco that are working on substance abuse-related issues were contacted. The Planning Consultant conducted a literature review and interviewed thirty key informants. A community newsletter, *R.A.D.A.-Call*, was created and disseminated to the persons in the database as well as to the community at large, serving as both an introduction to and a progress report on the Master Plan. In June, provider surveys were sent out to over 1,000 agencies in the five focus areas to develop a picture of current resources and services.

In May of 1991, representatives from health, welfare, education, law enforcement, and the private sector attended the first Master Plan Advisory Body (MPAB) Meeting. The seventy-five participants were divided into the four focus teams; a fifth team was established for the business/private sector. A Planning Matrix was provided to each focus group, in which participants were asked to identify existing services, describe service needs and strategies for addressing unmet needs, identify priorities, and make recommendations for improving services. The focus groups continued to meet throughout the summer to refine recommendations made at the MPAB Meeting, and to work on specific problem areas in greater detail for inclusion in the Master Plan.

Among the activities planned for Year II are:

- Further elaboration of the Needs Assessment component. Development of a needs assessment inventory and a summary analysis of key substance abuse indicators. This information will be disseminated to planning bodies such as the Master Plan Advisory Body, the City-Wide Alcoholism Advisory Board, the Drug Abuse Advisory Board.
- These planning bodies will use the above information to further refine goals, set priorities, and develop measureable objectives and strategies for implementation of needed services. Services will be developed based on an extensive knowledge of needs, gaps in services, resources available, and innovative models of care.
- In order to assure broad community representation in the planning process, further outreach and publicity efforts are being planned.
- The establishment of a strategic plan to engage the private sector in a partnership with public substance abuse, health and other social services is key to involving all aspects of the City and County.

The Goal of the Master Plan

The primary goal of the Master Planning process in San Francisco is to utilize the widest possible audience of respondents and participants for gathering information, analyzing data, setting goals, and making recommendations for reducing substance abuse problems in the County. Preliminary recommendations came from the focus groups established at the May MPAB meeting, key informant interviews and the provider surveys. Other comments and recommendations were provided by the City-wide Alcoholism Advisory Board, the HIV+ Planning Council, the Mission Leadership Forum, the Drugs and Disabilities Task Force, Health Commissioners; and other task forces, planning groups, and concerned parties.

For purposes of organization and clarity and based upon similarities, specific recommendations were arranged under eight categories :

1. To improve coordination, collaboration, and communication among all systems serving the substance abusing population of San Francisco.
2. To assure the involvement of interested participants from all of San Francisco's diverse communities in planning for substance abuse prevention and treatment services.
3. To establish a system that assures treatment on demand that is accessible to everyone.
4. To expand intervention programs for engaging people into treatment.

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5. To increase the availability and effectiveness of substance abuse prevention.
6. To improve the quality of services by affecting systemic change.
7. To increase revenues for a comprehensive substance abuse system.
8. To develop a system that is responsive and able to adapt to the ongoing Master Planning Process.

The recommendations contained in this document is reflective of our current status in the planning process and will serve as a departure point to continue our discussion among the focus teams and Master Plan Advisory Body in Year Two. Planning is an ongoing process and our first year laid the foundation for building our future agenda for substance abuse services in San Francisco.

I Executive Summary

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II.

Introduction:

Planning will reduce alcohol and other drug problems in San Francisco



**SAN FRANCISCO
DRUG REBELLION**

Preface

Alcohol and other drugs have always played an important role in our celebrations, rituals, medical practice, and in our social problems. Alcohol and other drugs have been continually redefined and viewed from different perspectives—sometimes as evil rum, other times as the great elixirs, in the 19th century as moral disorders, and in the early twentieth century as diseases. Most recently alcohol and other drug use is being seen as a social problem that affects virtually every corner of American society; from the boardrooms of corporate America, to the crack houses in the housing projects, afflicting Hollywood stars as well as the skid row wino on the streets.

In the 1980's increased attention to substance abuse created a flurry of projects specifically designed to address this pervasive social problem. Though all solutions did not result in the desired effects, there was the overall nationwide awareness that alcohol and other drugs were more than just a symptom of social and economic malaise. In many cases alcohol and other drugs were the problem itself. Confronting addictive behaviors, changing the norms of acceptable behavior, and reasserting some basic standards did ameliorate what had seemed as very intractable problems. But now we have to look at the next steps. What are the long range local strategies which can help to fundamentally reshape the organization of our community so that substance abuse is not such a deleterious factor in social problems in the future?

The San Francisco County Master Plan project is designed as a strategic management planning process and coordinating system for enhancing, promoting, and improving local substance abuse prevention, intervention, treatment and aftercare efforts. The Plan is a key component in San Francisco's efforts to develop and implement a community-wide multi-disciplinary, comprehensive, neighborhood, systemic, and client-oriented strategic planning process to address the City's serious alcohol and drug abuse problems.

The Master Plan process builds on considerable local effort to assess problems, identify gaps, and attack the issues of drug and alcohol abuse, and their related problems in San Francisco. The leadership and key participants necessary to complete this comprehensive systems approach have already been convened through various ongoing planning efforts, including the Mayor's Drug Symposium Task Force, Homeless Task Force, (CJAG?), the Planning Advisory Group of the Division of Mental Health, the Citywide Alcoholism Advisory Board, the Drug Abuse Advisory Board, the AIDS and HIV Task Force and others. Additionally, while the planning process encompasses all of San Francisco's communities, the current Alcohol and Drug Report and the Strategic Plan for Mental Health have identified a number of neighborhoods as high priority underserved populations.

The Master Plan provides a renewed impetus for task force members, community leaders, health and social service providers, the private sector, parents and youth to continue planning additional alcohol and other drug service activities. Businesses and private foundations have also expressed enthusiasm in joining this partnership for expanded approach to comprehensive grassroots, peer oriented substance abuse service planning. The Plan will identify and coordinate the ongoing planning processes, oversee the development of a needs assessment, identify gaps and unmet needs, establish a clearly defined set of priorities and strategies, and design a blueprint for a comprehensive and collaborative substance abuse service delivery system.

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Community Substance Abuse Services

Planning Efforts

The Past

The San Francisco Department of Public Health has had a long history of analyzing alcohol and other drug problems in this City. Needs assessments have been prepared, research based household surveys have been conducted, key informants have been interviewed, drug indicator data has been collected, community forums have been held, advisory bodies have helped set priorities, and blue ribbon task forces have been convened. State law since 1976 has required annual assessments of alcohol and drug problems. Each year, as required by the Department of Alcohol and Other Drug Programs and State law, Community Substance Abuse Services (CSAS) has submitted a report (The Combined County Alcohol and Other Drug Program Plan) on the ways in which these problems are being addressed.

In the mid 1980's planning began to take on a different form due to the complexity of the substance abuse related problems in relation to other health care concerns (e.g. AIDS and mental illness) and also due to the burgeoning Federal effort to prevent and treat alcohol and drug abuse. In 1988 the Board of Supervisors requested a five-year spending plan for the development of treatment services to accommodate fully the various target populations in need of substance abuse treatment. This plan outlined the basic prevention and treatment strategies in existence, namely residential care, detoxification, methadone treatment, outpatient treatment, day treatment, and prevention related services. CSAS developed a presentation targeting populations such as adolescents, substance abusers at risk for HIV, and women's services. That analysis projected rough estimates of need, and defined state, local and federal funding that might become available. The plan called for the increase in substance abuse prevention and treatment to a stable peak of over forty million dollars by 1992.

During the 1988-90 period San Francisco substance abuse policy makers advocated for the establishment of funding formulas that based the distribution of resources on the estimate of persons unable to be served but in need of treatment. CSAS service providers began collecting data on persons placed on waiting lists and federal law makers passed legislation that allocated resources according to the existence of waiting lists. San Francisco collected a disproportionately large share of these resources (6% of all Federal funds, 26% of funds received in California).

Current and On-Going Planning Efforts

The City-wide Alcohol Advisory Board and the Drug Abuse Advisory Board are critical to substance abuse planning in San Francisco. In addition to reviewing and recommending proposals for services and evaluating the quality of program service delivery, both Boards actively participate in the annual development of the County Plan as stated in the Health and Safety Code, Sections 11815 and 11983.1. Specifically, Advisory Board members develop priorities for substance abuse services and review the county budget for providing programs and services identified in the program plan.

Throughout the years, the Advisory Boards have convened various community forums providing a linkage for community access to the county planning process. These forums are driven by critical issues, such as dual diagnosis, or by neighborhood initiative. An excellent example of the Advisory Board's efforts is the Mission Leadership Forum which was initiated in 1987 and continues in developing long range action plans using social policy prevention strategies. A spin-off of the Mission Leadership Forum is the Mission Residential Drug Treatment Consortium targeting services for Latino/Latina

II. Introduction • History of Planning Efforts

adolescents. Other forums planned by the Advisory Boards include Aging and Addiction/Alcoholism, Gay and Lesbian needs assessment/planning, and Grandparents and Crack.

The DMSF Strategic Plan

Another major change in the Substance Abuse Planning efforts occurred in 1990 when CSAS participated in a Strategic Planning effort with the Division of Mental Health, Substance Abuse, and Forensics (DMSF). DMSF and CSAS share three basic operating principles: culturally competent, consumer based, and consumer guided. This collaboration laid some important groundwork for the Master Plan process.

Key points from the Strategic Plan are as follows:

- The 1990-91 Unmet Needs Projections identifies the necessity for expanded prevention and intervention strategies, especially for high-risk youth and pregnant addicts.
- An additional 17,520 individuals are in need of nonresidential drug free treatment services.
- Additional service enhancements include the development of case management for 1,250 clients, 1,000 clean and sober housing units and augmentation of residential treatment services by 4,235 beds.
- The 1989-90 Civic Center pilot project for the homeless, illustrates that immediate access to treatment coupled with long term sober and drug free housing have a significant impact on reducing substance abuse problems, relapse and homelessness.

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• 1990-91

History of Planning Efforts

Specific strategies identified in the 1990 Strategic Plan include:

- Expand inter-agency and community planning and development of projects through the creation of a County Master Plan to Reduce Alcohol and Drug Problems (SB 2599).
- Advocate for public policy changes aimed at increasing long-term funding for the War on Drugs and allowing for effective treatment options.
- CSAS seeks to expand services to meet current and emerging needs through federal, state, and local funding for the following target populations:
 - 1) Intravenous drug users and other substance abusers who are at risk for HIV infection;
 - 2) Crack/cocaine users, especially youth, pregnant addicts and their families;
 - 3) Dual and multiple diagnosis patients;
 - 4) Public inebriates and the homeless substance abuser;

- 5) Families;
- 6) High-risk youth

- Integrate drug and alcohol services into a substance abuse delivery system, while maintaining the inclusion of a strong alcohol-specific focus.
- Increase accessibility to comprehensive substance abuse service centers for seniors.

The Mayor's Drug Symposium Task Force

The Mayor's Office of Public Safety has received a five year Federal Office for Substance Abuse Prevention (OSAP) grant entitled Empowering Parents and Youth to address issues parallel those outlined in SB 2599. CSAS has taken a major step toward reducing unnecessary duplication by coordinating the master planning process with the EPY project underway in the Mayor's office. To simplify matters, individuals currently serving on the Mayor's Drug Symposium Task Force, which was organized in 1988, will function as the Master Plan Advisory Body. We believe our alliance with the Mayor's office will ultimately be beneficial to both projects.

San Francisco's Master Plan

Master planning activities began with the development of a database that includes over 1500 concerned individuals and organizations, from which the eighty current members of the Master Plan Advisory Body were appointed. More than a dozen committees and task forces in San Francisco that are working on substance abuse-related issues were contacted. The Planning Consultant conducted a literature review and interviewed approximately thirty key informants. A community newsletter, *R.A.D.A.-Call*, was developed and disseminated to the persons in the database as well as to the community at large, serving as both an introduction to and a progress report on the Master Plan. In June, provider surveys were sent out to over 1,000 agencies in the five focus areas to develop a picture of current resources and services.

In May of 1991, representatives from health, welfare, education, law enforcement, and the private sector attended the first Master Plan Advisory Body Meeting. The seventy-five participants were divided into the five focus teams. A Planning Matrix was provided to each focus group, in which participants were asked to identify existing services, describe service needs and strategies for addressing unmet needs, identify priorities, and make recommendations for improving services. The focus groups continued to meet throughout the summer to refine recommendations made at the MPAB Meeting, and to work on specific problem areas in greater detail for inclusion in the Master Plan.

Second Year Activities

We believe this document is a plan in progress and is reflective of our current status in the planning process. The ambitious goals and objectives set for Year One were difficult to achieve, yet provided us with a foundation to continue the planning process through year two.

Locally, the Master Plan will have at least two more iterations before it goes to the Health Commission and the Board of Supervisors. This draft will be reviewed and responded to by the Master Plan Advisory Body, both Drug and Alcohol Advisory

II. Introduction • History of Planning Efforts

Boards, and other interested parties during November. The Focus Teams will continue to meet and refine priorities, objectives, and strategies through March, 1992. In addition, two community forums will be held for general public reaction and input to further the development of a Master Plan. The State Department of Alcohol and Drug Programs is expecting the updated Master Plan from San Francisco by October 1, 1992.

Objectives: Year II

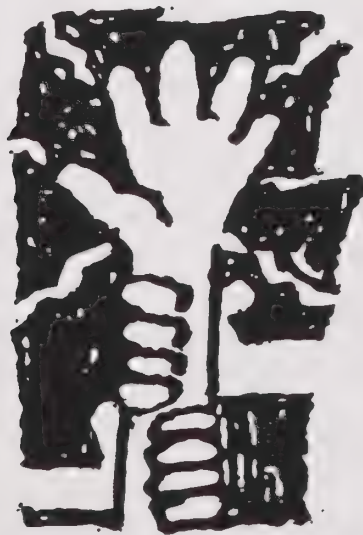
1. Enhancement and maintenance of a strategic planning effort which assures the identification of action steps and the implementation of planning objectives.
2. Enhancement of the Master Plan Advisory Body to insure the integrity of the planning process.
3. Development and implementation of a public awareness campaign to increase local knowledge and enhance community involvement in the Master Plan process.
4. Development of an updated Master Plan to reduce alcohol and drug problems in San Francisco.
5. Development of an Evaluation system to provide ongoing feedback on the Master Planning process.

II. Introduction • Objectives: Year II

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III.

ASSESSING OUR COMMUNITY'S NEEDS



**SAN FRANCISCO
DRUG REBELLION**

Description of County Demographics

City and County of San Francisco

The City and County of San Francisco is similar to many other urban environments characterized by highly diverse communities residing in densely populated and geographically restricted areas. Measuring only 47 square miles, San Francisco is estimated to have 741,300 residents (U.S. Census, July 1987 Estimates). These figures do not adequately illustrate the complexity and diversity of San Francisco's neighborhoods, the richness of its cultures and the magnitude of its substance abuse related problems.

San Francisco is one of the most ethnically and culturally diverse cities in the United States, ranking third, nationally, for recent immigrant relocation and ranking first for Asian and Pacific Islander immigration (CARECEN Report, 1988). According to 1985 census estimates, 47% of the city's residents identify with one or more ethnic communities - 13% Black; 12% Hispanic; .5% Native American; 22% Asian; and .5% other ethnic affiliation - and 54% are women. While there are no confirmed numbers for the county's gay and lesbian residents, estimates range from 5 to 20% of the total population. San Francisco is a relatively youthful city with 17% of its residents under the age of 18 (Health Data Summaries)

San Francisco's children and youth have been particularly impacted by the increase of alcohol and drug use, especially crack cocaine, over the last few years. Between 1986 and 1988 there has been a 167% increase in the number of substance abuse related child abuse dispositions (Department of Social Services). Additionally drug related youth arrests have jumped from 442 in 1986 to 1012 in 1988, nearly a 130% increase over two years (Juvenile Probation Data).

While the County Master Plan applies to all neighborhoods, several specific communities have previously been identified (DMSF Strategic Plan, Mayor's Drug Symposium) as being high impact areas. The planning process has paid particular attention to the needs of these neighborhoods, which include: (1) the Western Addition; (2) the Tenderloin; (3) Potrero Hill; (4) the Mission District; (5) Bayview Hunters Point; (6) Visitacion Valley/Sunnydale; (7) the OMI (Oceanview-Merced-Ingleside); and 8) Chinatown. Although not geographically contiguous, these neighborhoods share many indicators of socioeconomic and health status problems including high numbers of low-income ethnic minorities, crowded substandard housing, unemployment, single-parent families, low-birthweight deliveries, and high rates of sexually transmitted diseases. A high incidence of substance abuse related problems is also shared by the members of these target neighborhoods, such as crack-cocaine use, gang-related violence, drug-related arrests, child abuse and neglect referrals, cocaine-affected births, arrests for narcotics violations and homelessness. Additionally, access to existing drug treatment services is inadequate, as measured by an average waiting period of three months for entry into services.

The Western Addition

The Western Addition is one of the poorest areas within San Francisco. It is characterized by its predominantly (54%) young Black families, low incomes, high incidence of poverty, and multiple family housing. It is also the neighborhood which has the highest percentage of families led by single parents (SFUSD). There are significant concentrations of children and young to middle age adults. The mean family income is only half of the City average. Juvenile law offenders from the Western Addition comprise 13 percent of the detainees at Juvenile Hall.

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The Tenderloin

Residents of the Tenderloin tend to be the poorest residents in the City. This neighborhood has the highest percentage of its youth belonging to families which receive Aid to Families with Dependent Children (AFDC). The Tenderloin contains large concentrations of the elderly, South East Asians, and urban poor, living in group quarters facilities and apartments. As immigration continues to rise, this community has witnessed a significant increase in alcohol outlets, one of the highest in the city. The population contains significant percentages of adults age 35 and over. Labor force participation rates are the lowest in the City (ABAG, SF Social Area Analysis, 1988).

The Mission District

The Mission District is home to the largest Hispanic population in the City. The population is young and 39% of families are headed by single parents. Of the employed, half are in blue collar occupations. Nearly 40 % of the population live in overcrowded housing units. Youthful law offenders from the Mission comprise 15 percent of the detainees at Juvenile Hall. According to Coleman Youth Services, the Mission is also one of the neighborhoods with the most poor families.

Bayview Hunters Point

Bayview Hunters Point has become one of the most economically depressed areas of the City. In 1986, 40% of the youth who resided within this neighborhood received AFDC (SFUSD). Blacks are the predominant ethnic group in this area (76%) (PIC, 1980 Census). The loss of industry in this neighborhood (Hunters Point shipyards) has exacerbated the high unemployment rate (SFUSD).

Visitacion Valley/Sunnydale

Visitacion Valley/Sunnydale has been experiencing an influx of Hispanics and since 1986 has been home to a growing Filipino community. Another major population group is children with 33% of the population under the age of 19 (SFUSD). This area also includes the Sunnydale Housing project, one of the largest and most problematic in the City. The homeless population living in the neighborhood park is very young (21 years median age) and predominantly Black (61%). Fifty four percent of the households receive public assistance and only 36% of the population 16 and over are employed. Juvenile law offenders from Visitacion Valley/Sunnydale comprise five percent of all detainees.

Potrero Hill

Potrero Hill contains a young, family-oriented population that is ethnically and racially diverse. Recent surveys indicate that 25 % of the population is black and 14% is Hispanic.. Although it appears from school enrollment patterns (elementary has increased 17% between 1980 and 1986) that many of the "older" families who reside within this area are moving out, the neighborhood has retained the working class atmosphere that developed in the 1940's (SFUSD). Approximately 34% of the families are headed by single women and 51% of the areas children reside in these families. Juvenile law offenders from the Potrero comprise seven percent of Juvenile Hall detainees.

Oceanview-Merced-Ingleside

The OMI neighborhood has a family-oriented population living in single family homes. Nearly half of the workers are blue collar. This area has a large percentage of children, including 18% of the areas residents under the age of 15. Major population groups are persons of African American, Spanish origin and Asian/Pacific Islander (mostly Filipino) (ABAG, 1984). Even though the OMI was not among the neighborhoods with the lowest median household income, it was among the neighborhood/zip code areas with the highest concentration of Department of Social Services (DSS) recipients (Department of Public Health Perinatal Health Report, July 1989). Juvenile law offenders from the OMI comprise approximately 8% of the detainees in Juvenile Hall. There are no substance abuse services located in this community.

Chinatown

Chinatown is a small geographical community with the highest population density in San Francisco, the city with the highest population density west of the Mississippi. As the area's population density continues to increase, there has been a corresponding rise in juvenile gang violence and drug using activity. Chinatown's population is almost 63 % foreign born. Over 76 % of the people do not speak English and 51 % of the adults have not finished high school. Asian youth constitute over 25 percent of the San Francisco's public school population, with ethnic Chinese the predominant group(25%) (SFUSD). Juvenile law offenders from Chinatown comprise six percent of the detainees in Juvenile Hall.

These eight target neighborhood areas have a constellation of socioeconomic and health status problem indicators. The Tenderloin ranked as one of the City's neighborhoods with the lowest median household income, approximately \$7,226 (1980 Census). It was followed by among others, the Western Addition, Mission, Potrero Hill and Bayview Hunters Point. Although we are now more than a decade away from the 1980 Census, current knowledge confirms that these neighborhoods generally remain the poorest in the city (DPH Perinatal Health Report, July 1989).

Although no neighborhood is totally homogeneous, disadvantaged racial/ethnic groups appear to be concentrated in the poorest neighborhood areas. Bayview Hunters Point, Potrero Hill and the Western Addition have substantial low income Black populations and are the sites of several large public housing projects.(DPH Perinatal Health Report, 1989).

The low birthweight rate for all San Francisco births was 6.5%. In four neighborhood areas including nearly 15% of all births in 1987, the rate of low birthweight deliveries was above 9%; these areas are included in the target community and are the Western Addition, Tenderloin, Potrero Hill and Bayview Hunters Point.(DPH Perinatal Health Report , 1989).

III. Assessing Our Community's Needs . Description of County Demographics

Substance Abuse Indicators

Implications for Alcohol and Other Drug Problems and Services

While San Francisco accounts for only two and a half percent of California's 27,662,900 inhabitants, it carries a disproportionately high rate of alcohol and drug related incidents. The definitions of use, abuse and addiction vary among professionals, cultures and communities, which is particularly important to understand when dealing with the diversity of cultures found in San Francisco. CSAS defines abuse as the use of a drug to the detriment of one's own or others' health and/or functional abilities. Addiction is defined as the physical or psychological dependence on a substance. In abuse and addiction, there is a progression of use which may lead to dysfunction and/or ill health.

Substance abuse is a disabling illness which places at risk a significant portion of the population in the county's neighborhoods. It does so, dramatically, when individuals from the neighborhood die in emergency rooms from drug overdose; from AIDS contracted as a result of high-risk substance abuse related behaviors; and from drug-related violence, such as an auto accident or an event of gang violence. The target neighborhoods are home to and are being terrorized by these gangs and the problem appears to be escalating (*San Francisco Chronicle*, March 21, 1989). Too frequently, parents, youth and neighbors in these target areas attend the funerals of young people killed because of drug-related incidents or being caught in the cross-fire of gang fights. Less dramatic, but pervasive and insidious, are the long term health and social effects of drug and alcohol abuse on the individuals and families. Besides the effect of individual social and functional deterioration, the cycle of addiction will affect the entire family constellation over many generations. The illegal activities and the dysfunction of these individuals and families is resulting in high socioeconomic costs to these neighborhoods, the county and the state.

The following indicators profile the extent and effect of substance abuse and related behaviors in San Francisco:

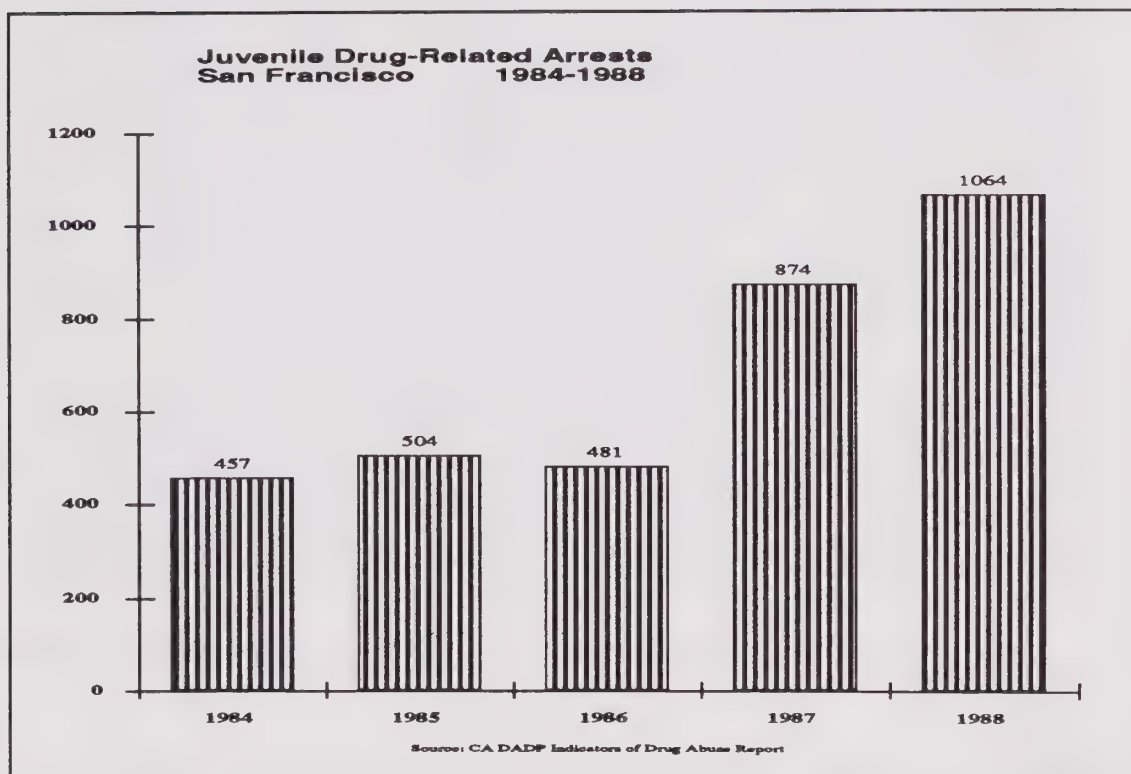
AIDS

San Francisco has the second-highest per capita rate of Human Immunodeficiency Virus (HIV) infection in the United States, surpassed only by New York City. There are an estimated 16,000 addicts in San Francisco who in any given year inject their drugs of choice, usually heroin or cocaine. Since 1981, 10,837 cases of AIDS have been reported in San Francisco, with injection drug users (IDU's) making up the second-highest risk group for transmission of the virus (13%). San Francisco has about 13,000 intravenous drug users who report weekly use; 16% are HIV infected. The rate for minority substance abusers is 26%. Recent studies have shown that between 14% and 20% of IVDU tested are HIV positive and that rate is increasing (CSAS Updated Plan, FY 88-89). Seroprevalence rates among heavy crack users in San Francisco have been reported as high as 16%. CDC studies of street recruited crack users in San Francisco who have never injected needles indicate HIV rates of 15%. When Community Substance Abuse Services matched its alcohol treatment program clients with AIDS cases, researchers found a 7.5% prevalence rate as compared with general population rates of less than 1%. Substance abuse related HIV disease is the most significant health problem facing San Francisco. The sexually transmitted disease rates per 100,000 population, an indicator of risk for HIV infection, are much higher in the target neighborhoods than the County's overall rate (SF City Clinic).

III. Assessing Our Community's Needs • Substance Abuse Indicators

Youth Substance Abuse

According to the National Institute on Drug Abuse, the National Household Survey on Drug Abuse-West Coast shows that 30% of youth (ages 12-17) have used an illicit drug, 21% have used an illicit drug during the past year and 1 % used during the past month. The National Household Survey-Nationwide also reports that 50% of youth(ages 12-17) have used alcohol and 25% are current users (used at least once in that last 30 days prior to survey).



III. Assessing Our Community's Needs

• Substance Abuse Indicators

Many of the county's neighborhoods have a significant population of high-risk, multiple problem youth most of whom are using drugs and/or are at immediate risk of beginning drug use. A recent behavioral health survey conducted in San Francisco high schools by the University of California, San Francisco, shows an alarming 30-60% of the students engaging in high risk substance abuse behaviors (DiClemente, 1987). Youth from the target communities comprised 77% of all San Francisco Unified School District suspensions associated with substance abuse (SFUSD). Youth drug-related arrests more than doubled from 442 in 1985 to an estimated 1080 arrests in 1989 (SFPD). Seventy-eight percent of Youth Guidance Center (San Francisco's youth detention center) drug referrals were of youth from the target communities.

Drug-Related Crime

Based upon data from 1989, there were an estimated 15,000 drug-related arrests; a 57% increase between 1986 and 1989 statistics. In 1988, the target communities accounted for 85% of San Francisco's narcotics violations, an increase of 67% from 1986 (SFPD). There were approximately 2,000 parolees in San Francisco last year. Seventy-five percent were from the target neighborhoods. The California Department of Corrections conservatively estimates that 35% of these ex-offenders are at high risk of substance abuse related recidivism and are in need of substance abuse treatment, support and re-entry services.

Cocaine-related deaths in San Francisco rose from 5 to 15 between 1976 and 1989. Crack-related youth gang violence has increased from four gang-related shootings resulting in one homicide in 1987 to over 100 shootings in 1989, resulting in nine homicides. There are approximately 54 drug gangs in San Francisco whose membership numbers over 5,000. The target communities are home to over 80% of these youth (SF Mayor's Office, Drug Prevention & Education for Youth Gangs, 1989). Petitions filed for youth drug-related offenses increased from 100 in 1983 to over 700 in 1988; the increase is almost entirely the result of increases in cocaine-related offenses (SF Juvenile Probation). The number of minorities and youth responding to the economic incentives for participating in the trafficking of the drug cause both despair and value conflicts in these communities as the members experience the effects on their families and their cultures.

Homeless Persons/Mentally Ill

Current estimates of the number of homeless persons in the city on any given night are 5,000 to 6,000. The S.F. Department of Public Health estimates that at least 40-50% of the homeless in San Francisco also are substance abusers. A study of homeless individuals in San Francisco concluded that 22.4% of those interviewed had received psychiatric services within the previous year; 34.7% had a history of psychiatric hospitalization and 47.7% had a history of alcohol or drug abuse (CSAS Updated Plan FY 88-89). There are large numbers of homeless individuals living in the Tenderloin and Mission neighborhoods.

San Francisco Coroner's Deaths

Cocaine, heroin, amphetamines or PCP were involved in 311 Coroner's cases in FY 89/90 (Figure P). These illicit drugs were found as "drug caused deaths" in 219 cases, "drug related deaths" in 59 cases and "role unclear/incidental" in 33 cases. Alcohol was involved in 213 cases, representing 36% of all accidents, suicides and homicides. Heroin/opiate drug mentions increased 49% from 185 in 1986-87 to 275 1988-89. Cocaine mentions increased 116% from 70 in FY 85/86 to 151 in FY 88/89. During the same time period alcohol-in-combination mentions increased 26% from 131 to 165 while amphetamine mentions peaked at 70 and then stabilized to their original level.

Accidents

Alcohol involvement was mentioned in 134 accidents representing 38% of all accidents. Average blood alcohol content was .20 . Positive alcohol tests were found in 58% of auto driver fatalities, 33% of motorcycle driver fatalities, 43% of drug overdoses, 33% of falls, 30% of head traumas and 29% of burns. Other drugs were found in 212 non-vehicular accident cases or 71% of all non-vehicular accidents.

Suicides

Alcohol was involved in 39 suicides representing 31% of all suicides. Average blood alcohol content for suicides involving firearms was .23 . The highest rate of positive alcohol tests were found in 67% of cutting/stabbings, 40% of bridge jumpers, 39% of drug overdoses, 35% of hangings, 33% of asphyxia/suffocations, and 26% of firearms. Other abused drugs were found in 23 cases, representing 18% of all suicides.

Homicides

Alcohol involvement was mentioned in 40 homicide cases representing 40% of all homicides. Average blood alcohol content for stabbings was .20 . Positive alcohol tests were found in 56% of stabbings, 50% of head/blunt traumas, and 43% of firearms. Other abused drugs were found in 31 cases representing 30% of all homicides.

III. Assessing Our Community's Needs • Substance Abuse Indicators

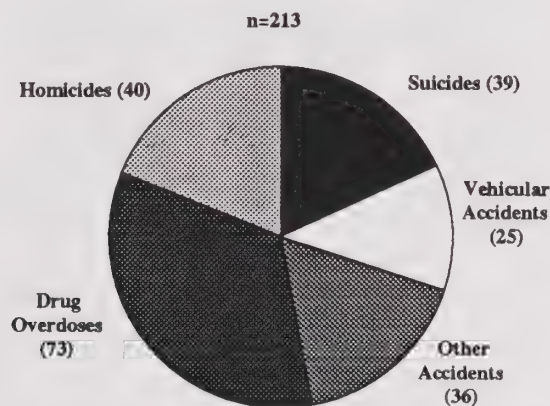
Age, Race, Gender

Demographic breakdowns for drug caused/related deaths varies greatly by type of drug and whether drug was present singly or in combination. Blacks were at highest risk among cocaine deaths reaching 51% for "drug caused" present in combination. Latinos were at highest risk for PCP deaths reaching 100% for "drug caused". Whites represented the highest proportion of heroin and amphetamine deaths reaching 78% for "drug caused" heroin alone and 89% for "drug cause" amphetamines alone. Younger aged people were at highest risk for PCP and cocaine deaths (25-35 yrs.) while heroin and amphetamines were mostly found among ages 31 to 41. Females were at high risk for cocaine deaths (22%) and heroin deaths (25%) "drug related" in combination. Prevalence of substance abuse among American Indians is estimated to be as high as 40% in San Francisco.

Yearly Trends

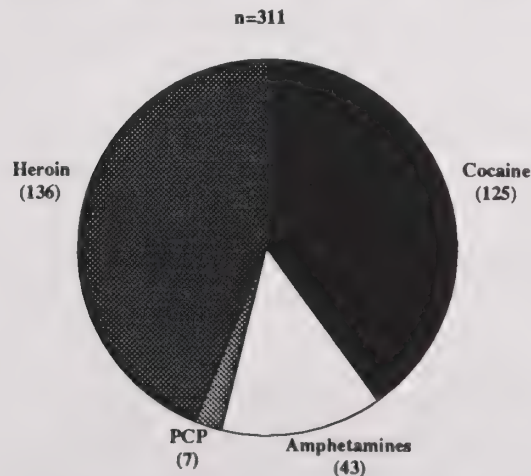
Cocaine deaths decreased slightly from 1983 to 1985 but rose substantially from 1986 to 1990. There was a 22% increase from 58 to 71 in the latest fiscal year. Heroin deaths were moderate in the mid '70s, low in the late '70s and have risen to new highs during the '80s. There was a 10% increase from 101 to 111 in heroin caused death from 1988 to 1989. Below is a chart from the Coroner's Annual Report illustrating the types of death involving alcohol and other drugs.

San Francisco Deaths Involving Alcohol, FY 89/90



Source: SF Chief Medical Examiner-Coroner, Annual Report, FY 89/90.

San Francisco Deaths Involving Drugs, FY 89/90



Source: SF Chief Medical Examiner-Coroner, Annual Report, FY 89/90

III. Assessing Our Community's Needs • Substance Abuse Indicators

Alcohol Involved Vehicular Accidents in San Francisco

California Highway Patrol's *1990 Annual Report of Fatal and Injury Motor Vehicle Traffic Accidents* indicates a doubling of alcohol involved deaths since 1987 and an 11% increase in alcohol involved injuries from 1,076 in 1988 to 1,193 in 1990. Monthly patterns for 1990 indicated that May and August/September were peaks for alcohol involved deaths and injuries. In 1990, alcohol involved deaths accounted for 37% of all vehicular deaths in San Francisco (n=84) compared to only 31% in 1987.

Narcotic Arrests in San Francisco

There has been a relatively constant number of juvenile arrests between 1984 and 1988, but a 130% increase in the number of juvenile arrests for narcotic related offenses between 1984 (457) and 1988 (1,064). In 1984, arrests for narcotic related crimes constituted 1/10 of all arrests; in 1988 they accounted for 1/5 of all arrests. Petitions filed in Juvenile Court for drug-related offenses have increased from approximately 100 in 1983 to 700 in 1988. Seventy-eight percent of Youth Guidance Center (San Francisco's youth detention center) drug referrals were of youth from the target communities.

Families Affected by Substance Abuse in San Francisco

For every alcohol or drug-addicted person, approximately four other people are adversely affected. There has been a fourfold increase in child abuse and neglect referrals since 1982 (2,121 to 8,412). One indicator of the increasing problem, the percent of child abuse and neglect dispositions based upon alleged parental substance abuse, increased from 32% in 1986 to 68% in 1988 (SFDSS). The number of children committed for out of home placement and never returned to the home went from 1226 in 1988 to 1960 in 1990, a 60% increase. The percentage of children placed in foster care because of alleged parental drug use rose from 32% in 1986 to 71% in 1989.

Gang violence, crack sales and use, sexually transmitted diseases, teen pregnancy, failure in school, unemployment, domestic violence and juvenile crime are just a few of the many problems that families in this country are facing today. These problems seem to escalate when the families live in public housing.

Eighty percent (80%) of families living in our developments are single women, head of household. Many of the women are teen parents and/or grandparents trying to raise children in the midst of the drug epidemic, and in a country where children are the fastest growing poverty group. The median income for residents is \$8,000 a year.

Alcohol Abuse

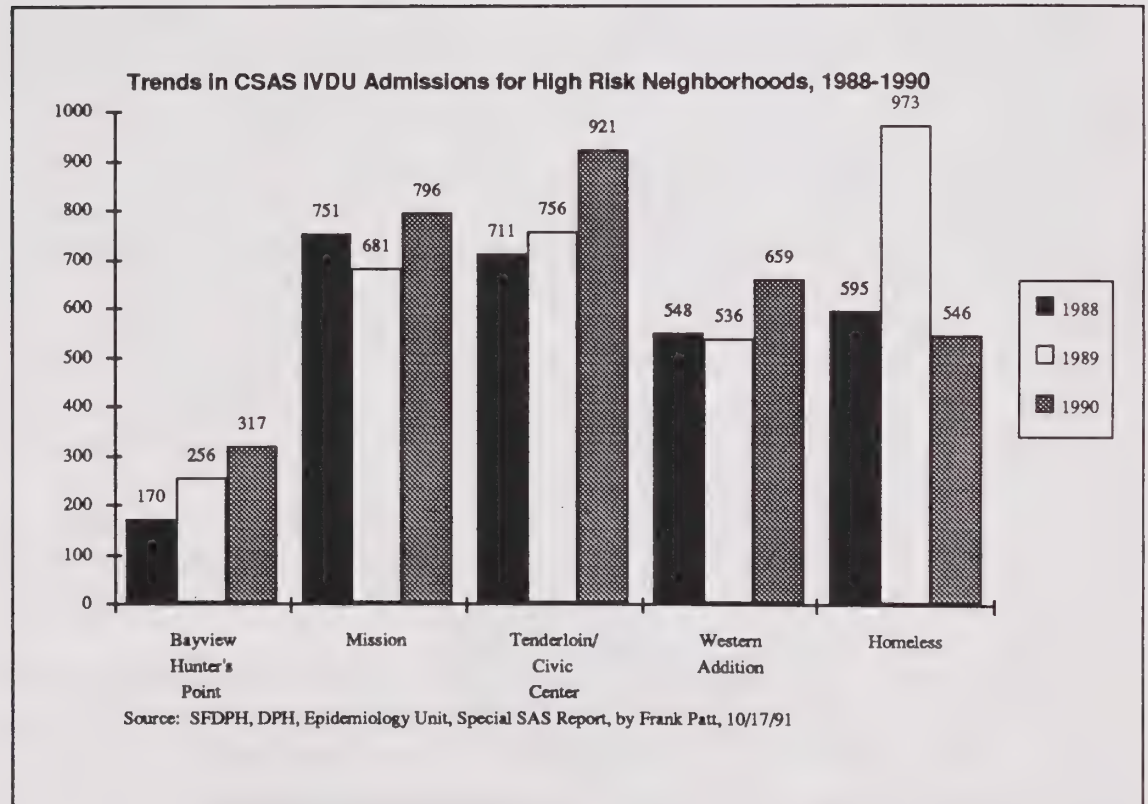
There are approximately 500 retail liquor licenses per 100,000 persons in San Francisco. The availability of alcohol in San Francisco is twice as great as Statewide estimated of other Bay area cities. The estimated prevalence of alcohol addiction in San Francisco is very high. In 1988, there were an estimated 134,000 (17%) high frequency drinkers and over 70,000 problem drinkers. The results of a survey of students conducted at Balboa High School in one of the target neighborhoods in May and June of 1985 showed that 49% of the students have experimented with alcohol and 14% use alcohol weekly. These results are believed to be low due to underreporting. It is estimated that 7-12% of the senior population of San Francisco suffers from alcohol abuse and its attendant problems. In a 1985 study of suicides in San Francisco from 1970 to 1980, 35% of the 617 deaths of persons over age 60 were a direct result of the ingestion of drugs and alcohol (CSAS). Cirrhosis of the liver is an indicator of alcohol abuse. Deaths resulting from this disease were evident in the population of the target communities, which included 59% of the total SF cases in 1987 (1987 SF Death Certificate Records, SFDPH).

III. Assessing Our Community's Needs • Substance Abuse Indicators

High Risk Neighborhoods

Data from the 1988-89 AMEN cohort study of 1700 unmarried San Franciscans aged 18-44 living in three of the Master Plan's target neighborhoods -- Bayview-Hunter's Point, the Western Addition, and the Mission -- indicated that 10.7% had injected drugs. Of these, 2.3% had shared their needles with partners or other persons. Fifty-eight percent of current IDUs surveyed had not sought drug treatment in the past year. Eleven percent of respondents used crack and 31% used cocaine within the last year. Four percent used heroin or other opiates. Twenty-one percent used alcohol heavily.

The table below illustrates increasing numbers of injection drug users from high risk neighborhoods admitted into CSAS programs in 1990.



III. Assessing Our Community's Needs

Substance Abuse Indicators

HIV Infection and Transmission to Newborns

The Center for Disease Control (CDC) reports in 1991 HIV seroprevalence rates of 5 to 19 per 10,000 women in California. Studies of seroprevalence among injection drug users in San Francisco methadone maintenance programs indicate 9% or 900 per 10,000 women carry the AIDS virus. The CDC indicates that 82% of HIV infected mothers are asymptomatic and that perinatal transmission rates to their newborns range from 36 to 53%. These high rates are due to prenatal blood transmissions and postnatal colostrum and breast milk transmissions.

Studies conducted in 1989 by DPH and Catholic Charities suggest that 720 drug exposed babies are born each year in SF, representing 7% of all resident births. At SFGH between 250 - 300 drug exposed births are identified yearly, representing 12 - 15% of all SFGH births. These estimates are understated due to testing & protocol variances by hospitals & clinicians and existing toxicology screening methods.

The Pediatric High Risk Clinic at San Francisco General Hospital reported that the number of cocaine-addicted babies has quadrupled since 1983 with a significant rise in

the last 18 months. In 1988 there were an estimated 175 cocaine-related births. Reports for 1989 indicate over 300 births with positive toxic screens.

Women

On a National level, according to a recent survey over 5 million (9%) of the nearly 60 million women of childbearing age (15-44 yrs.) had used illicit drugs at least once during the past month.

Women of childbearing age represent approximately 25% of the total population of SF County; only 20% of the City's drug treatment population are women of child bearing age.

In a paper presented at the 1991 International Aids Conference (Fullilove) 38.5% of the women who used mind altering substances had sex while under the influence of alcohol or drugs.

Lesbian and Gay Substance Abuse

Findings from a 1990 community survey of lesbians and gay men include the following:

One third of HIV positive gay and bisexual men said they had unsafe sex during the past year while drunk or high. Twenty-eight percent of gay and bisexual men and 26% of lesbian and bisexual women said they were recovering from AOD use; at least half of these had been in recovery for more than a year. Gay and bisexual men appear to use alcohol and other drugs more often, in greater amounts, and in combination more frequently than men and women in the general population.

Nearly one-third (31%) percent of gay and bisexual men reported using alcohol and/or other drugs at the highest risk level established for this survey, which reflects likely chemical dependency and for many, addiction. Another 11 percent reported AOD use in the next highest risk category, describing use patterns that were potentially problematic. This means that as many as 42 percent of gay and bisexual men currently may be using AOD at risky levels. Forty percent of all gay men and 30% of lesbian and bisexual women said they used drugs other than alcohol.

Bisexual women reported AOD problems at rates that were substantially higher than lesbians.

Costs of Substance Abuse

According to the Department of Alcohol and Drug Programs (DADP) substance abuse problems cost the state of California \$17.7 billion (\$11.7 billion for alcohol abuse and \$6.0 billion for drug abuse) or \$631 for every man, woman and child (*Indicators of Alcohol and Drug Abuse Trends, 1989*). The estimated minimum cost for San Francisco exceeds \$463,783,738 through reduced productivity, auto accidents, crime, and social welfare programs. This cost estimate has not been adjusted upwardly to include the increased prevalence of substance abuse problems and the impact of HIV spectrum disease on the county. The estimated multi-agency cost of crack-cocaine addiction alone in 1987-88 was \$72 million. This cost included approximately \$22.2 million devoted to social services, particularly for children in foster care, \$11.2 million for health services spanning treatment for addicted infants to outpatient and inpatient treatment for adults; \$4.6 million for juvenile justice; and \$34 million for criminal justice, law enforcement and probation activities. A conservative calculation by the Department of Public Health for the 1988-89 year attributes expenditures of over \$16 million on crack-cocaine abuse, through the utilization of community substance abuse treatment programs, adult hospital inpatient services, perinatal care and public health nursing.

III. Assessing Our Community's Needs • Substance Abuse Indicators

Current Substance Abuse Services Delivery Systems

Health:

Community Substance Abuse Services is the primary substance abuse service provider in the Department of Public Health. CSAS employs a prevention model of substance abuse services. Full implementation is limited by funding constraints, resource limitations, and a growing demand for services, often resulting in 3 to 6 month waiting lists for individuals seeking treatment. Nonetheless, CSAS has been a leader in the design and utilization of comprehensive, multi-cultural alcohol and drug abuse services.

CSAS presently has contracts with 30 alcohol, drug and health service agencies, and provides more than 72 different programs to San Franciscans. These programs represent a continuum of care which includes primary and secondary prevention, and community-based treatment services. Among the service options currently available in the Health Department are: Residential Services specifically for African American males, Asians, homeless, Native Americans, and women with children; Outpatient services are available to virtually every population, regardless of drug use history. In addition to those populations mentioned above, outpatient services are available to gays and lesbians, high risk youth, Latino families, and pregnant addicts. Treatment protocols include drug free, acupuncture, pharmacological regimens, family therapy, group counseling, individual therapy, case management, primary care augmentations, and support groups. Other service options include: Methadone Maintenance and Detoxification; and other detoxification services including alcohol residential, drug outpatient, and opiates; Information, assesment and referral.

In 1990-91 CSAS provided treatment services to 9,264 unduplicated drug and 7,693 unduplicated alcohol clients, of which 51 percent were White, 32 percent Black, 12 percent Latino, 4 percent Asian and 1 percent Native American. (Research Information System). According to a four year client demographic survey (University of California, Berkeley Alcohol Research Group and RIS, March 1990) of alcohol detoxification clients, 92.5 percent were homeless in 1987. For 1990-91 CSAS services included 514 Residential alcohol and drug beds providing nearly 172,701 treatment days. CSAS also provided approximately 207,132 non-residential alcohol service units and 708,453 non-residential drug service units (1985-90 Cost and Annual Clinic Reports).

Services for San Francisco employees include Employee Assistance Programs (EAP) for all city agencies, and for a number of private businesses in the city. All businesses with over 15 employees have alcohol and drug policies based on the Drug-Free Workplace Act of 1988.

Social Services

The San Francisco Department of Social Services and community service providers have identified substance abuse related problems as a major impact on their clients. Over the last few years, social services agencies in San Francisco have targeted the homeless substance abuser and pregnant addicts as priority populations (Mayor's Homeless Plan 1989).

In August, 1989, the Mayor's Office of Homeless, Department of Social Services, and representatives of Community Substance Abuse Services participated in a pilot homeless services project which targeted nearly 300 homeless individuals frequenting the Civic Center Plaza area of the city. The purpose of the project was to test new interventions specifically designed for this population. Interventions were implemented through a collaborative effort of the Mayor's Coordinator of Homeless Programs,

III. Assessing Our Community's Needs • Current Substance Abuse Services Delivery Systems

Veterans Administration, Department of Social Services; along with Adult Medical , Forensic , Mental Health , and Community Substance Abuse Services of the Department of Public Health. The project tested new approaches in service delivery for the homeless, such as eliminating individual appointments at multiple service sites by bringing multiple services to the homeless person. A triage team, consisting of the above-mentioned agencies, made assessments of each individual's immediate and long term needs. A service delivery plan was established based on these needs and, through a case manager, services were immediately initiated. Transportation and immediate access to services was provided to all participants. Accessibility to substance abuse services was a key factor in providing help to the target population

•Education

Community Substance Abuse Services is built upon two guiding principles: Prevention and Collaboration. The limited availability of financial resources and the immense loss of human potential requires innovative solutions to the city's substance abuse problems. Currently, over 20% of CSAS's Federal Block Grant dollars are expended on various school and community based prevention activities. CSAS funds both alcohol and drug hotlines; Multi-Cultural Training Resource Center; National Council on Alcoholism; Center for Human Development; Community, School and Juvenile justice based peer counseling programs; along with a host of innovative projects (CADRE, SOS, HELP, TB/CDC, PALS, MAP, SAFE, etc.).

In addition to the school based programs directly funded by CSAS there exist significant resources, services and planning initiatives in the school through Proposition 99, Assembly Bill 75, the Federal Drug-Free Schools and Communities Act, "Here's Looking At You 2000" Education curriculum implemented by the San Francisco Police Department, and a host of others.

III. Assessing Our Community's Needs

• Current Substance Abuse Services Delivery Systems

The San Francisco Unified School District has had a remarkably succesful record of developing school based drug prevention programming. Some highlights of current programs include:

- **Here's Looking at You, 2000**, a comprehensive drug education program, in grades K-5.
- **Youth Aware**, an alcohol education program, presents three lessons about alcohol and alcoholism in grades 1-5.
- **Strengthening Family Ties**, parent workshops focusing on how to strengthen family ties, are conducted by the Center for Human Development.
- Third graders are involved in **Smoke-Free Class of 2000** programs co-sponsored by the American Lung Association, the American Cancer Association, and the American Heart Association.
- A system of elementary school **health advocates** was established during the 1990-1991 school year.

Middle Schools:

- **Me-Ology**, a comprehensive drug education program, is taught by sixth grade core teachers as part of a nine-week course in health education.
- **Clear Choices** and **Clear Choices II** has been implemented in the seventh and eighth grades during the 1990-1991 school year.
- **Project M-Power**: Eight of 17 middle schools are participating in a three-year pilot program which includes multiple prevention, identification, referral, and intervention program components. As part of this pilot, student assistance teams and peer resource programs have been established at each of the pilot middle schools.

High Schools:

- All tenth grade students receive **tobacco, alcohol, and drug education** as part of a nine week health education course.
- Each high school has a **peer resource program** in place. Some high schools have a full-time peer resource coordinator while others utilize existing staff during their preparation periods.
- The American Lung Association has trained thirteen high school teachers to conduct **Freedom from Smoking**, a six-week smoking cessation program.

Other educational services available in San Francisco include:

- the **WEDGE** Program which provides AIDS education
- **Teens Kick-Off (TKO)**: Works with recovering teens to perform personal stories on substance abuse.
- **National Council on Alcoholism and Other Drug Addictions**: Provides in-service training and education about addictions and co-dependency, education in the workplace.
- **Family Mosaic** - Case management and coordination for emotionally disturbed kids.
- **After-school youth training and employment** - Focus Team members claim that ten agencies are involved
- **Asian Youth Substance Abuse Project** - Consortium of Asian agencies providing education and counseling to youth.
- **San Francisco Police Department** - Wilderness Project
- **Head Start** - Teaches parenting skills, substance abuse education

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Criminal Justice

Community Substance Abuse Services has been meeting regularly with Forensics and others to address the substance abuse needs of incarcerated individuals. Currently, CSAS funds the only substance abuse peer education and counseling program at the Youth Guidance Center for detained and incarcerated youth. CSAS also funds one of the few jail diversion projects, Substance Abuse Referral Unit (SARU), available to prospective inmates. Due to the 1988 Consent Decree, which ruled that San Francisco's jails were overcrowded and thus unconstitutional, a major reorientation is taking place within the criminal justice system.

Beginning in the 1989-90 fiscal year a pilot jail diversion project has been initiated. The purpose of this project is to divert public inebriates from the jails into residential detoxification programs. Inherent to this effort in the expansion of mobile transportation vans, additional alcohol detoxification beds and additional long-term residential treatment beds for those individuals deemed appropriate for services.

Public Housing

A comprehensive list of available housing services in San Francisco is provided by the San Francisco Housing Authority Drug Prevention and Intervention Project, K. Deborah Whittle, Director.

The Project, which is funded through a grant from the U.S. Department of Housing and Urban Development (HUD), has been in operation since February 1989, under the direction of Resident Services. The success of this project has been through the collaborative efforts of the residents, San Francisco Housing Authority staff, the Mayor's Office, Project SAFE, City agencies and supporting community agencies.

We have been very successful in implementing programs at four target sites, (namely, Alice Griffith Public Housing, Plaza East Public Housing, Sunnydale Public Housing and Valencia Gardens Public Housing) and have begun duplication at five additional sites.

Other Services

There are many services outside the system of Health Department sponsored substance abuse treatment and prevention programs. Community development agencies, park and recreation department activities, church programs, and the Department of Social Services all have programs which serve addicted individuals or their families. Much of the service need and gaps identified in the indicator data section. Examples of other social and community services include:

- Western Addition - Middle School Age Program
- YWCA
- Grandparents Who Care - Raising Kids of Drug Addicted Parents
- U.C. Deafness - Assessments, etc.
- Asian Youth Substance Abuse Project with High Risk Youth
- Housing Authority Drug Prevention Programs

- Booker T. Washington
 - a) Tutorial program for kids
 - b) Summer camp for kids
- Youth Guidance Center /Log Cabin Ranch - substance abuse program for all youth, YGC and LCR
- After-Care Program 10 community-based organizations
- Prevention Services - approximately 5 community-based organizations involved.
- CAAB/DAAB oversee evaluation funding of cell program planning, e.g., "Grandparent" Conference (crack)
- Morrisania West: provide substance abuse prevention and counseling, education, do advocacy work, peer counseling. They have 45 slots. Substance abuse issues are involved in 80% of them. They also provide youth employment.
- Adult Probation Department (ADP) acts as brokers/advocates for services.
- Jail Psychiatric Services (JPS) - provides screening, IT and GT in jails
- Waiting list groups
- County parole/harm detention clients
- Case management
- A number of businesses have Employee Assistance Programs
- All businesses with over 15 employees have alcohol and drug policies based on the drug free work place laws
- All city agencies have EAP

Friendship House and Native American Services

There are an estimated 9,000 American Indians in the City and County of San Francisco. The Friendship House has 20 beds available for drug/alcohol treatment. It is the only American Indian treatment program in the City and County which consists of 90-day residential and 90-day Aftercare treatment.

Eighty-percent of the Friendship House's clients have used both alcohol and drugs, ages 18-35. Twenty percent use alcohol only, ages 35-65.

Services for Gay men, Lesbians, and Bisexuals

It is impossible to determine how many gay and bisexual men and lesbians and bisexual women receive AOD services since programs are not mandated to collect statistics on program participants' sexual orientation. A handful of programs provide some AOD services to gay men; only one targets lesbians. No residential program exists for lesbians, and only one for gay and bisexual men. More AOD services are available to gay men than to lesbians. Several of these are linked to HIV prevention, treatment, and support programs.

III. Assessing Our Community's Needs • Current Substance Abuse Services Delivery Systems

While the majority of programs serving the general population appeared aware that they served lesbians, gay men, and bisexuals, many seemed uncomfortable dealing openly with sexual orientation issues. Half of these programs said they provided some form of sensitivity training to staff about gay and lesbian issues, but less than one third have formal policies addressing homophobia among staff and other clients. Similarly, only one third provide any visual welcoming clues, such as brochures, posters, or other written material that specifically address lesbians or gay men.

While one quarter of gay and bisexual men, and lesbian and bisexual women reported participating in 12 Step Programs, and around 16 percent said they were seeing professional counselors for AOD problems, twice as many men than women reported receiving services from an AOD inpatient or outpatient facility. This suggests a lack of services, or barriers to services, for lesbian and bisexual women, rather than low demand.

Gay men, lesbians, and bisexual men and women appear to be significantly underserved at every point on the service continuum. Lesbians are particularly underserved, and bisexuals appear to be invisible to the service system. Availability of services appears to be limited by three key factors: lack of services specifically targeting these populations; lack of sensitivity and openness among AOD-related programs serving the general population; and cost of services and waiting lists.

III. Assessing Our Community's Needs • Current Substance Abuse Services Delivery Systems

Description of Collaborative Efforts

Studies and practical experience indicate that substance abuse is a burgeoning problem which defies traditional health, social, economic and political boundaries. A fundamental principle of San Francisco's approach to alcohol and drug problems is through collaboration and coordination. Over the last four years CSAS has participated in over 35 inter-departmental planning efforts. CSAS's collaborative activities go beyond participation in planning Task Forces, to securing cross disciplinary funding of programs, co-location of services and staff, and sharing of resources. Gang violence, homelessness, alternatives to incarceration, multiple diagnosis, children and family health, HIV spectrum disease, drinking driving programs, social services, community empowerment, and education are some of the issues CSAS and others work with on a daily basis.

Collaboration has occurred in a number of projects, including the following:

The PALS Project

The Primary Addiction Linkage Services (PALS) program is an integral component of the San Francisco substance abuse and HIV strategic plan. This overall plan has three elements. The strategic plan outlines the development of substance abuse treatment which virtually allows for "same day service" for drug users seeking drug treatment. The plan also calls for peer outreach into indigenous communities to recruit into treatment people at risk of using drugs. The PALS project becomes an integral part of the current and expanded treatment and outreach system, linking substance abuse treatment to health care services.

To achieve the goals and objectives of this project, we have established three components. First, we expanded primary care services and develop substance abuse services for the Tom Waddell Clinic, an urgent care facility with a high case load of minority IVDUs. Second, we added substance abuse counselors/case managers to two primary health care centers (Southeast Health Center and the Haight Ashbury Free Medical Clinic) with similar treatment populations of minority IVDUs in their case loads. The counselor/case managers at Southeast continue to strengthen their liaison with Bayview-Hunter's Point Foundation (a substance abuse treatment program). The Haight Ashbury Free Medical Clinic provides both medical and substance abuse treatment. Third, we will employ an addictionologist and an addictions medicine fellow (physicians knowledgeable in psychiatric and substance abuse medicine) to train San Francisco health care professionals in addictions and to be available on a case consultation basis for twenty drug treatment clinics.

Multi-Service Youth Center

The multi-service Center targets multiple problem high risk youth on a city wide basis and merge existing social, educational, community, recreational, and vocational services with new prevention intervention and drug abuse day treatment programming. The program is located at the Booker T. Washington Recreation Center, operated by the San Francisco Department of Parks and Recreation, and is located in a central part of the City easily accessible from all neighborhoods, and strategically situated near a public housing project with high rates of drug abuse problems. This close proximity will benefit the project residents who have been determined by the Mayor's Office as high in need for affiliated services.

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Save Our Sisters (SOS) Project

This project is primarily an outpatient counseling/case management model with the intent of decreasing perinatal substance abuse. Referrals to the program come from DSS and other perinatal clinics who see prenatal and postpartum women.

The Safe Places Project

The purpose of the SAFE Places project is to reduce alcohol or drug abuse among participants. This will be accomplished by providing Substance Abuse Free Environments (SAFE), personalized advocacy and a comprehensive case monitoring component that is linked to the complete range of medical and social service agencies in San Francisco.

CADRE

Consisting of a comprehensive continuum of outreach and counseling services for children and youth, CADRE includes representatives from community-based multi-cultural alcohol and drug prevention, intervention and treatment providers, the Office of Juvenile Justice, Department of Social Services and Citizen Advisory Groups. CSAS currently funds peer counselors and mentors stationed at four secondary, two middle and four elementary schools.

Center for Human Development

School-based early intervention and prevention project targeted to parents of grade school children and middle and high school students. Refocusing on high risk students in community day schools.

National Council on Alcoholism

School-based early intervention and prevention project. Youth Aware provides a school-based alcohol and drug educational curriculum and support groups for grade school kids.

HELP

A prevention project which works with crack children entering the school system, including teacher training and support, and direct support for the students.

Horizons Unlimited

School based intervention for high risk youth and rap groups. Targeted to Latino youth.

Westside Youth Awareness and Multiple Problem Youth Programs

Treatment, prevention and intervention for high risk youth. Some interfacing with the school district.

Driver Training Orientation

A collaborative effort between the Mayor's Office, Juvenile Justice, CSAS, SFUSD, DMV, and Highway Patrol to provide education on alcohol and drug use as it relate to driving for high school students.

Suicide Prevention

Peer counseling and teacher training.

Morrisana West

School based peer counseling for high risk youth. Black focused.

Asian Youth Substance Abuse Project

A consortium of five youth serving agencies providing education, assessment, intervention and counseling to Asian youth.

ACCEPT

Provides education, assessment, intervention and counseling for high risk youth. Linked to with various middle and high schools.

Real Alternatives Program

Provides education, assessment, intervention and counseling for high risk youth. Linked to with various middle and high schools. Latino focused.

The GANG Project

Mayor's Office and the School District, gang education and prevention project.

The Mayor's In School Project

Assists students in finding jobs throughout the year as an alternative to drug use and to increase school retention.

Drug Free School Education Project

Education, intervention and student empowerment project for drug free schools.

Comprehensive Alcohol and Drug Prevention Education Project

A joint project with the Office of Criminal Justice Planning and the San Francisco Unified School District.

SARU

Criminal justice diversion project funded by CSAS for inmates entering the jails.

The Diversion Project

A pilot project funded jointly by CSAS, Forensics and the Sheriff's Office to provide detoxification and residential services to public inebriates who would otherwise be incarcerated.

Youth Guidance Center

CSAS currently funds the only substance abuse assessment, intervention and treatment program for detained and incarcerated youth in San Francisco.

Walden House

A long-term residential drug treatment program, funded by CSAS, targeted to substance abusing parolees.

The Mayor's Office Of Public Safety

CSAS is working closely with the Mayor's office and the Police Department on the SAFE Streets project, the Drug Free Housing Project, the Gang Prevention Project and the school-based education project (Here's Looking At You 2000) administered through the police department.

Mobile Assistance Patrol

A collaborative project between CSAS and the Police Department to pick up and transport public inebriates who are willing to enter detoxification services on a voluntary basis.

III. Assessing Our Community's Needs • Description of Collaborative Efforts

The Judicial Council for Alcohol and Drug Problems

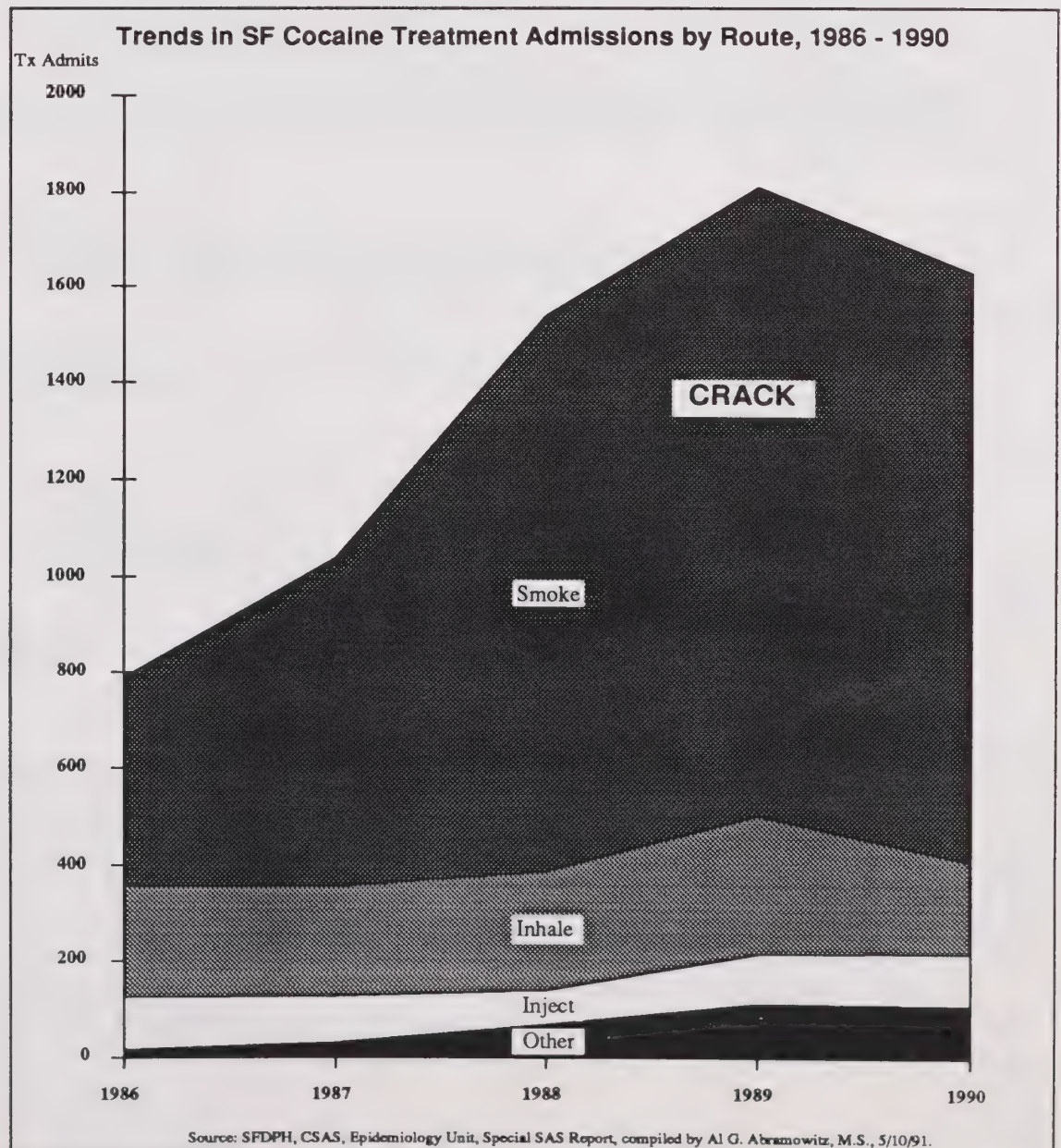
A task force of various judges seeking alternatives to sentencing for drug use related offenses.

Probation Department Diversion Project

Seeks to access substance abuse services for individuals being paroled.

One of the first priorities for the Master Plan is to identify and expand collaboration with both the school district and the various agencies working in the criminal justice system. The SFUSD, Department of Corrections, San Quentin, Forensics and the Mayor's Office of Public Safety met during fiscal year 1990-91 to address some of the specific needs and concerns of these two service areas.

III. Assessing Our Community's Needs • Description of Collaborative Efforts



Trends and Patterns Among Clients Served

Overall, there was a 16% increase in total CSAS drug program admissions from 1986 to 1990. While the percentages of heroin admits decreased since 1986 in relation to cocaine, the actual number of heroin admits increased from 6,070 to 6,508. Cocaine admissions doubled while Crack Cocaine admissions tripled. Barbiturate, Amphetamine, Marijuana and PCP admissions represented slightly less of the distribution in 1990. Needle sharing for all admissions and primary drug injecting decreased significantly.

Admissions under 26 years old represented 5% of the total in 1986 and 12% in 1990. The actual numbers increased 168% from 403 in 1986 to 1,081 in 1990. While sex distribution remained constant, the actual number of female admissions increased 15% from 2,999 in 1986 to 3,454 in 1990. Similar patterns are noted in ethnic distribution. While a greater percentage of the admissions were Black (41% increase), the actual number of admits in each race increased while their weighted distribution decreased relative to the increase among blacks, or remained stable.

Detoxification admissions decreased most dramatically, while residential and Outpatient Drug Free programs doubled their distribution and magnitude.

	<u>1986</u>	<u>1990</u>
Total Admits	8,173	9,480
Primary Drug Problem:		
Heroin	74 %	69 %
Other Opiates	1.5%	.5%
All Cocaine	10 %	17 %
Crack Cocaine	5 %	13 %
Other Cocaine	5 %	4 %
Barbiturates	.3%	.1%
Amphetamines	4.3%	4.0%
Marijuana	4 %	2.6%
PCP	1.2%	1 %
Other Drugs	4.7%	5.8%
Shared Needles Last Month	30 %	10 %
Inject Primary Drug	72 %	66 %
Demographics:		
Under 18	.2%	.7%
18-25	4.8%	11 %
26-35	33 %	35 %
36-45	47 %	40 %
Over 45	15 %	13.3%
Males	63.3%	63.6%
Females	36.7%	36.4%

III. Assessing Our Community's Needs • Trends and Patterns Among Clients Served

III. Assessing Our Community's Needs • Trends and Patterns Among Clients Served

Demographics:	<u>1986</u>	<u>1990</u>
White	54 %	50 %
Black	27 %	33 %
Latino	14 %	12 %
Asian	4 %	4 %
American Indian	1 %	1 %
No High School Diploma	29 %	28 %
Unemployed	75 %	71 %
Homeless	5 %	11 %
No Previous Treatment	24 %	26 %
Service Category:		
Detoxification	79 %	63 %
Methadone Maintenance	7 %	9 %
Outpatient Drug Free	12 %	24 %
Residential	2 %	4 %

Injection Drug Users (IDU)

Over six thousand IDU's sought treatment in DPH-funded clinics during Fiscal Year 90-91. This means that of an estimated 16,000 IDU's, 10,000 did not receive treatment. According to surveillance systems, the highest risk neighborhoods for IDU are the Mission, Western Addition, Bayview-Hunter's Point, the Tenderloin, and South of Market. HIV infection rate for this untreated population is estimated to be as high as 33%.

Of the 6,268 IDU's admitted to CSAS drug treatment during 1990, 64% were male, 36% were female; and 57% percent were white, 26% Black, 12% Latino, 3% Asian and 2% American Indian. Seventy-seven percent were between 26 and 45 years old. Nine percent were homeless. Ninety-four percent were admitted for heroin addiction and 27% reported some cocaine use. Most IDU's (45%) had completed high school only, while 26% had no diplomas, and 29% had some college or advanced studies. Seventy-eight percent of these clients were admitted to detoxification, 12% to methadone maintenance, 7% to outpatient drug-free programs and 2% to residential facilities.

Trends in IDU Admits and Needle-Sharing Behaviors

Since 1986, trends in demographics and behaviors have changed significantly. The most significant change has been in risky needle sharing which transmits HIV infection. There has been a 62% decrease in needle sharing among IDU's admitted to CSAS-funded programs from 1986 to 1990. In 1986, needle sharers represented 40% of all IDU admits (n=2,357) compared to 14% (n=887) sharing needles in 1990.

Crack and Cocaine Use

Thirty-eight percent of CSAS client admissions reported some cocaine use (primary, secondary, or tertiary drug of choice) in 1990, compared to 29%% in 1986. As the primary drug, cocaine use increased from 10% (n=789) in 1986 to 17% (n=1630) in 1990. Route of administration for primary cocaine users is reported in the graph on Page 42. For primary cocaine users the proportion reporting smokable cocaine increased over time from 55% (n=789) to 75% (n=1,630), while injecting and inhaling cocaine decreased (14% to 7% and 29% to 12%, respectively).

The proportion of crack users under 26 years old served increased from 7% in 1986

to 21% in 1990. Blacks represented 79% of crack clients in 1986 and also in 1990; Latinos represented 3% in 1986 and 5% in 1990. Crack clients admitted to outpatient drug-free treatment increased from 18% of all clients in 1986 to 70% in 1990. Conversely, crack clients admitted to detoxification treatment decreased from 75% in 1986 to 21% in 1990. Homeless crack users increased from 2% in 1986 to 7% in 1990. Unemployed crack clients increased from 65% in 1986 to 82% in 1990.

Overall, smokable cocaine use almost tripled (180%) from 432 clients in 1986 to 1222 clients in 1990 among primary cocaine users entering treatment in San Francisco. Latinos and youths under 26 account for increasing proportions of crack users, and Blacks constitute the majority of users in this sample. Sixty-one percent of admissions with primary or secondary cocaine problems were from the target communities, and half of those were from the Western Addition and the Mission Districts.

Drug Addicted Babies and Women of Childbearing Ages in San Francisco

During 1987-1990, female admissions to CSAS drug treatment programs increased by 18%. For those women aged 26 and below, the increase was 164%. During the same time period, female admissions to drug programs for cocaine increased by more than four times that of heroin. The proportion of nonwhite female admits increased by 31%.

A 1986-88 profile of 7150 CSAS female client admissions of childbearing age showed:

- 74% indicated heroin/opiates as drug of choice
- 70% were IV drug users
- 39% used some cocaine
- 5% used amphetamines and PCP
- 80% were unemployed

Services for Youth

During 1990-91 447 young people (up to 20 years) were seen in San Francisco Community Substance Abuse programs. Of these 447 clients receiving treatment 52% were African American, 23% White, 17% Latino, 7% Asian and 1% Native American. Admissions under 26 years old represented 5% of the total admits in 1986 and 12% in 1990. The actual numbers increased 168% from 403 in 1986 to 1,081 in 1990.

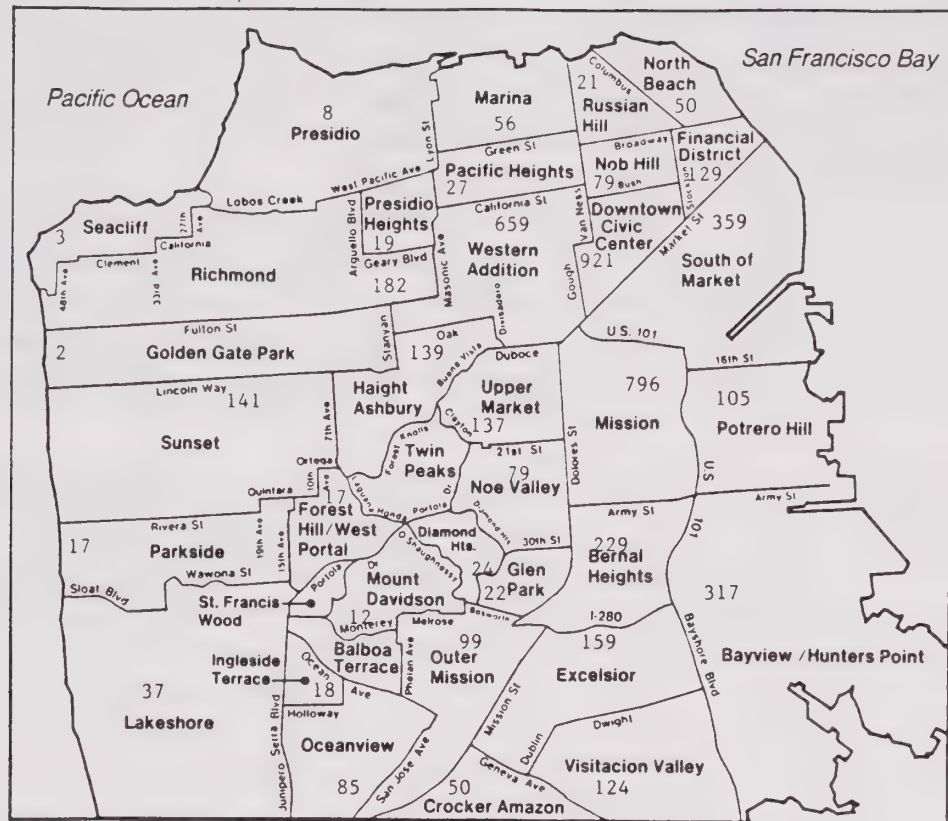
Residential Treatment for Drug Problems

During 1990-91, 480 clients received drug treatment in residential programs. The majority, (44%) received treatment for cocaine addiction followed by 28% for heroin/opiate addiction, 11% for amphetamines, 3% for PCP, 3% for marijuana addiction and 11% for other drugs.

A demographic profile indicates that 1% were American Indian, 10% Asian, 12% Latino, 36% Black and 41% White. Twenty-six percent were female, 6% were under 21 years old, 18% 21-25 years, 47% 26-35 years and the remaining 29% were 36-64. Ninety-three percent had been unemployed 30 days prior to admission. Thirty-six percent of these clients currently had minor children. One hundred seventy-five clients injected their primary drug and of these 20% had shared needles in the 30 days prior to admission. Two-thirds of these sharers had shared needles with two or more other persons.

III. Assessing Our Community's Needs . Trends and Patterns Among Clients Served

Profile of 6,268 IDU's Admitted to CSAS Programs, 1990



Transient 546
Non-S.F. 354
Unable to Ascertain Address 246

III. Assessing Our Community's Needs

Trends and Patterns Among Clients Served

ETHNICITY	#	%	AGE	#	%
White	3,585	57	Under 18	4	-
Black	1,646	26	18 - 25	369	6
Latino	750	12	26 - 35	1,912	30
Asian	206	3	36 - 45	2,938	47
Amer. Indian	81	2	Over 45	1,045	17
TOTAL	6,268	100%	TOTAL	6,268	100%

DRUG OF CHOICE	#	%	SEX	#	%
Heroin/ Other Opiates	5,895	94	Male	4,007	64
Cocaine	109	2	Female	2,261	36
Amphetamines	243	4			
Other	21	-	TOTAL	6,261	100%
TOTAL	6,268	100%			

NEEDLE SHARING LAST MONTH	#	%	ANY COCAINE USE	#	%
Yes	887	14	None	4,575	73
No	5,381	86	Some	1,693	27
TOTAL	6,268	100%	TOTAL	6,268	100%
MODALITY	#	%	EDUCATION	#	%
Detoxification	4,915	78	No Diploma	1,648	26
Methadone Maint.	777	12	High Sch. Grad.	2,847	45
Outpatient Drug-Free	438	7	Some College	1,369	22
Residential	138	2	College Graduate	306	5
TOTAL	6,268	100%	Advance Studies	98	2
			TOTAL	6,268	100%

Source: SFDPH, CSAS Epidemiology Unit, Special SAS Report, Al G. Abramowitz, M.S. -- 8/91

Analysis: Gaps in Service and Unmet Needs

Indicators and Service Utilization

Below is some preliminary information on several areas of gaps in service and unmet needs. A more comprehensive analysis of service gaps will be prepared for the Master Planning Advisory Body early in Year II. For example, the number of persons with substance abuse problems, broken down by major demographic categories (age, sex, ethnicity and other), will be compared with the number in each category which have recently received treatment, to identify major gaps in service to specific populations.

Intravenous Drug User's: There are an estimated 16,000 addicts in San Francisco who in any given year inject their drugs of choice, usually heroin or cocaine. Of these, only approximately 6,000 IVDU's sought treatment in publically funded clinics during FY '90-91, leaving roughly 10,000 addicts in need of intervention and/or treatment.

Homeless Substance Abusers: It is conservatively estimated that 40%, or 2,000 of the minimal 5,000 homeless persons in San Francisco are substance abusers. Only roughly 1,000 clients seen by CSAS-funded programs in 1990 were listed as homeless.

Disabled Substance Abusers: Mobile Assistance Patrol does not have a wheelchair lift equipped van. Drug-free policies in treatment programs serve to exclude people with disabilities who require drug therapy. Priority waiting lists for the disabled do not exist for accessible programs.

Waiting List for Substance Abuse Programs

In a 1989 MIS report, CSAS found that 7,380 persons were on waiting lists for treatment. Thirty percent were female, 56% non-white, 42% IDU, and 17% under 26 years old. Sixty percent were waiting for treatment at drug programs while 40% waited for alcohol treatment. During the quarter of January-March, 1990 waiting lists by modality were as follows:

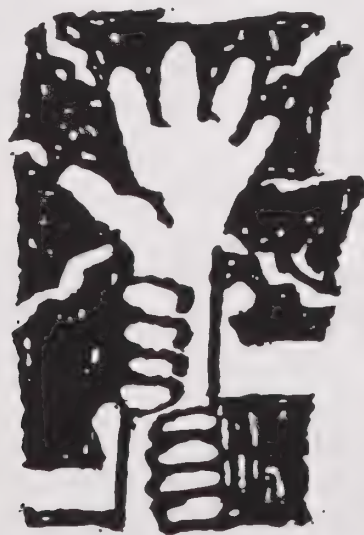
Type of Program	Number on List	Average Wait in Weeks
Methadone Maintenance	265	6.6
Outpatient Drug-Free	162	2.9
Outpatient Detox	149	0.8
Residential Drug-Free	115	2.3

III. Assessing Our Community's Needs • Analysis: Gaps in Service

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The solution is in our hands.**

IV.

The Master Planning Process



**SAN FRANCISCO
DRUG REBELLION**

Attainment of Objectives: Year I

The Master Planning project has provided the County of San Francisco with an opportunity to build upon the initial work and the processes established by the Mayor's Drug Symposium Task Force, the Division of Mental Health, the AIDS Plan, the Drug-Free Schools Plan, and a host of other efforts. Our primary goal, consistent with Senate Bill 2599, is to establish a community partnership for the reduction of alcohol and other drug related problems in San Francisco. Throughout the County Master Planning project, attention has been focused on the development of community-based, culturally appropriate, consumer-oriented services which are accessible to all in need and of high quality.

Objectives for Year I, and progress in attaining them, are as follows:

Objective One: To establish a system and network of interagency agreements, Memoranda of Understanding and collaborative communications to initiate and implement an effective planning process.

- CSAS has received 70 Interagency and Individual Agreements to Participate from service providers and administrators in the five different focus areas. Coordination among CSAS, DMSF, SF Unified School District, the Department of Social Services, and the criminal justice system has improved through involvement in the Master Planning process. The common mission of developing an effective Master Plan has brought greater focus and a sense of purpose to collaborative efforts, which in turn have become more productive as a result.

Objective Two: To establish an interdisciplinary, multi-cultural and community-oriented County Master Planning Advisory Body.

- On May 30, 1991, CSAS hosted its first Master Plan Advisory Body meeting. Approximately seventy-five people, representative of San Francisco's diversity and geographically balanced, attended and actively participated. Each focus group has met several times since then to develop their preliminary recommendations for

**IV.
The
Master
Planning
Process
•
Attainment
of Objectives:
Year I.**

Objective Three: To conduct a comprehensive needs assessment of services, needs, gaps, utilization and trends related to alcohol and other drug use and abuse in San Francisco.

- A provider survey was sent out to over a thousand individuals and organizations, soliciting information on current services and service needs. The response rate was low (approximately 8%), but some useful qualitative information was gleaned.
- Approximately thirty key informants, including provider administrators, educators, criminal justice officers, ministers, researchers, and community activists, were interviewed during the first half of 1991.
- CSAS Epidemiology staff provided extensive substance abuse indicator and service utilization data for the Master Plan. This information will be analyzed and presented in detail to the Master Plan Advisory Body during Year II.
- An extensive literature review was conducted, and a number of epidemiological surveys, reports, and plans were collected and analyzed. (These documents will be made available in detail to the Master Plan Advisory Body during Year II.)
- Further needs assessment information will be gathered and reviewed in Year II, including information on innovative models of treatment in other communities.

**IV.
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Attainment
of Objectives:
Year I.**

Objective Four: To enhance and sustain a strategic planning effort which assures the identification of action steps and the implementation of planning objectives.

- The strategic planning effort has been supported and enhanced through the efforts of the CSAS Planning Staff and the Master Plan Advisory Body to involve the community in the planning process. The process of creating the Master Plan Advisory Body itself has engaged concerned citizens, community organizations,

and leaders in the provider community. (Participation of the business community has been minimal as yet.)

- Extensive information has been gathered for the needs assessment in Year I. Early in Year II, CSAS Planning Staff intend to disseminate this needs assessment data to MPAB and other planning bodies in greater detail, including complete copies of various studies relating to specific populations and subgroups. In this way priorities can be further refined, and measureable objectives and strategies for implementation of needed services can be developed which are based on an extensive knowledge of needs, gaps in service, resources available, and innovative models of care.

Objective Five: To establish a system of information-sharing which is responsive to local requests and needs as well as requirements of the State Department of Alcohol and Drug Programs.

- Focus teams established at the MPAB Conference in May, 1991 have continued to meet and have been very effective in bringing together experts in each of the focus areas to plan for improved substance abuse services through the various service delivery systems in San Francisco.
- The Master Plan database contains over 1500 individuals, businesses, agencies, and organizations. Broad public awareness of Master Planning efforts is critical for successful implementation of the Master Plans. Several publicity efforts were developed during Year I, with more activities planned for Year II.
- We have produced two issues of a quarterly Master Plan newsletter. Our first issue of the *R.A.D.A.-Call* was distributed to the 1500 listings in the database the first week in March, and *R.A.D.A.-Call #2* came out at the beginning of September. Copies of the newsletter are attached. The name *R.A.D.A.-Call* is an acronym for “Reducing Alcohol and Drug Abuse”, and coincides with our “radical” theme and our motto:

**IV.
The
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Planning
Process
•
Attainment
of Objectives:
Year I.**

Join the San Francisco Drug Rebellion. The Solution is in Our Hands!

- We are being assisted by the Civic Affairs Committee of the Ad Club, a consortium of advertising and public relations firms that do *pro bono* work for nonprofit agencies. The recently-completed brochure will serve as the cornerstone of our efforts to involve the private sector

in the Master Plan during the second Planning Year.

Objective Six: To prepare a comprehensive County Master Plan to Reduce Alcohol and Other Drug Problems in San Francisco.

- The preliminary Master Plan was developed and submitted on September 30, 1991. The Master Plan Advisory Body, CSAS advisory boards, the DPH Intradepartmental Working Group, department heads from the four focus areas, and the Health Commission, will review and refine the preliminary plan during the Fall of 1991. The final version of the Year I Master Plan will be submitted to the State in January, 1992. This plan will then be updated and submitted for Year II on September 30, 1992

**IV.
The
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Process
•
Attainment
of Objectives:
Year I.**

Master Plan Structure and Objectives: Year II

1. To enhance and sustain a strategic planning effort which assures the identification of action steps and the implementation of planning objectives.

- Develop a detailed planning process and calendar of activities and milestones by October 15, 1991. CSAS will submit this to DADP in the December quarterly report.
- Establish an internal plan working group across the Department, among the Division and sections of the Division by October 15, 1991. This working group will meet regularly to review the Master Plan process, update objectives and coordinate other departmental planning activities.
- Convene department heads from Criminal Justice, Education, Social Services, Health, and others to participate in the planning process. Department heads will be contacted by October 31, 1991, for the first Inter-departmental Substance Abuse Council to be held by November 30, 1991. The purpose and frequency of meetings will be determined by the Council.
- CSAS staff to gather additional needs assessment data, including substance abuse indicators, service utilization data, and identification of gaps in service and unmet needs; for presentation to the Master Plan Advisory Body and CSAS advisory boards by November 15, 1991.

2. Maintenance of Master Plan Advisory Body and linkage to both the Drug Abuse Advisory Board and the City-wide Alcohol Advisory Board.

- Develop and implement strategies designed to increase participation from members of the Private Sector, parents, youth and veterans. These four populations were determined to be absent from the Master Plan Advisory Body in Year One. Therefore, CSAS will develop outreach strategies to engage representatives to participate. Initial contacts will be made in mid-October and continue through the second year.
- Develop strategies for involving clients and providers in the Master Plan process. In Year One, the Master Plan Advisory Body consisted of publicly funded providers. Year Two will focus on involving non-publicly funded health and substance abuse providers. In addition, CSAS will work with these providers to identify and involve clients in the planning process. These contacts will be made in mid-October and continue through the second year.

IV. The Master Planning Process • Structure and Objectives: Year II

**IV.
The
Master
Planning
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•
Structure
and
Objectives:
Year II**

- Develop procedures to expand or initiate interagency networking to establish/maintain collaboration on common issues. As identified in recommendations of year one focus teams, collaboration among providers who serve similar populations is necessary to provide a continuum of services. In addition collaboration is needed in the submission of grant proposals to reduce duplication of effort and services. This objective will be achieved by the Master Plan Advisory Body, or a subcommittee of that body. Development of the procedures will be initiated by January 15, 1992.
 - Create or expand committee assignments, roles, and/or responsibilities. In review of year one, the City-wide Alcoholism Advisory Board members and the Drug Abuse Advisory Board members both expressed their desire to participate in a more active and influential level. Beginning October 15, 1991, CSAS will establish various work groups from the Master Planning Advisory Body and the Advisory Boards to gather and review Needs Assessment data; develop an analysis of findings; refine goals ; develop measureable objectives; and draft strategies and structure for implementation. These work groups will meet as needed throughout year two.
- 3. Develop and implement a public awareness campaign to increase local knowledge and enhance community involvement in the master plan process.**
- Convene community forums to promote the Master Plan and to gather additional input on recommendations and strategies. Both the City-wide Alcoholism Advisory Board and the Drug Abuse Advisory Board, along with CSAS are sponsoring community forums for seniors and the lesbian and gay community in October. In addition, CSAS is sponsoring a youth conference in mid-November. Two general public forums will be held in target neighborhoods in the months of February and April 1992.
 - Develop public service announcements and press releases to mainstream and neighborhood press prior to the two general forums. Public service announcements will be sent to a minimum of six electronic media. Press releases will be sent to a minimum of ten general, neighborhood and ethnic print media.
 - Continue to produce the R.A.D.A.-Call newsletter as a bi-annual publication. The newsletter will inform the Master Plan Advisory Body and the general public on developments and events of the Master Plan Process.

4. Development of an updated Master Plan.

- To submit an updated Master Plan to the Department of Alcohol and Drug Programs by September 30, 1992. After the work groups complete their preliminary work, CSAS will reconvene focus groups to examine findings, confirm recommendations and develop short and long-term strategies for addressing priority needs identified in each service system—Education, Health, Social Service, and Criminal Justice.

5. Development of an evaluation system to provide ongoing feedback on the Master Planning process.

IV. The Master Planning Process • Structure and Objectives: Year II

San Francisco County Master Plan

Budget: Year II

July 1, 1991-June 30, 1992

Consultants

Planner I	\$ 4,876
Planner II	23,400
Asst. Planner	25,877
TOTAL	\$54,153

Budget Justification

Planner I contracted through September 30, 1991 at \$23.00 per hour for approximately 212 hours.

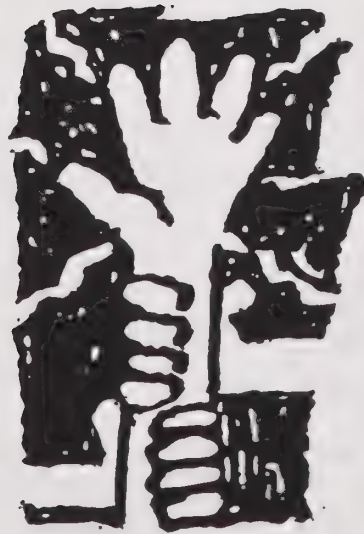
Planner II contracted September 9, 1991 through June 30, 1992 (42 weeks with 2 weeks off) at \$30.00 per hour for 20 hours per week.

Asst. Planner contracted through September 30, 1991 at \$13.00 per hour for approximately 412 hours (\$5357) and renewed contract for October 1, 1991 through June 30, 1992 (40 weeks with 2 weeks off) at \$18.00 per hour for 30 hours per week (\$20,520).

IV. The Master Planning Process • Master Plan Budget: Year II

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*V.
Responses to the
Master Planning Process*



**SAN FRANCISCO
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Key Informant Interviews

We began our review of Substance Abuse problems, unmet needs, gaps in service, duplication of services, and the quality of communication and coordination between existing service providers with interviews conducted with key informants. The approximately 30 people interviewed include directors of drug treatment facilities, ministers, educators, highway patrol officers, police officers, researchers and community activists. Some of the responses to the interview question: “What would you like to see the Master Plan address or accomplish?” are listed below:

- “We need more services for pregnant addicts, people with disabilities, and the elderly.” There should be no new programs that are not accessible to persons with disabilities.”
- “We need Spanish audiovisual materials on substance abuse.”
- “We need prevention programs in the elementary schools. Prevention programs should follow kids from one level to another.”
- “Tobacco should not be ignored in substance abuse planning. Given that it acts pharmacologically like crack cocaine, tobacco issues should be tightly integrated with drug prevention.”
- “We must realize that substance abuse is a dysfunction of a lot of factors that need to be addressed. For example, economic well-being. Unless those issues are addressed simultaneously all this planning is in vain.”
- “We need to find strategies for reaching out to people who don’t want treatment.”
- “There should be a continuation of treatment without interruptions.”
- “Counselors should just address the substance abuse problems of lesbians and gays. If we treat homosexuality as an illness, we isolate people.”
- “The primary indicators for alcohol and other drug abuse among Latinos, African-Americans, and American Indians--namely, racism and poverty--should be stressed.”
- “We need to encourage and assist communities in being more proactive around issues of proliferation of liquor stores and billboards in Latino and African-American communities.”

V. Preliminary Goals and Recommendations • Interviews with Key Informants

Preliminary Goals and Recommendations

The Master Planning process in San Francisco has attempted to utilize the widest possible audience of respondents and participants in gathering information, analyzing data, setting goals, and making recommendations for reducing substance abuse problems in the County. A major portion of the goals and recommendations listed below came from the focus groups established at the May MPAB meeting. Specific recommendations were gleaned from the key informant interviews and the provider surveys. Other comments and recommendations were provided by the City-wide Alcoholism Advisory Board, the HIV+ Planning Council, the Mission Leadership Forum, the Drugs and Disabilities Task Force, health commissioners; and other task forces, planning groups, and concerned parties.

The recommendations are presented under each of the seven Master Plan Goals.

Goal I: To improve coordination, collaboration, and communication among all systems serving the substance abusing population of San Francisco.

Establish an Interagency Council on Substance Abuse consisting of department heads in Health, Mental Health, Education, Criminal Justice, Social Services, and Community Organizations.

This Council would review current policies and determine if they create barriers to treatment. For example, Medi-Cal will not allow mental health providers to see a patient who has a substance abuse problem, and in agencies where substance abuse services are provided mental health problems cannot be discussed. The policy requiring that alcohol and other drug treatment programs be "drug-free" limits services for dual diagnosis clients and substance abusers with disabilities. Criminal Justice providers specifically requested that the Department of Social Services make DSS entitlement applications available to individuals prior to their release from jail.

Assure integration of program services on a systemic level.

In order to improve the accessibility, quality and availability of services, communication and coordination between providers who serve common populations is necessary. Out-of-school kids, dually diagnosed, HIV+ clients were cited most often. Recommended strategies included the establishment of a case management system that can effectively handle clients with multiple problems; developing a newsletter to inform providers of current and new services, legislation, funding opportunities, model programs, activities, and trainings; and convening quarterly forums, annual conferences and events.

Establish a planning council for substance abuse and criminal justice professionals.

Lack of information, unsuccessful interventions and unavailability of services to the jail and probation populations have led the criminal justice system to virtually ignore an individual's substance abuse problem when developing a plan for the offender. A coordinating council of judges, prosecutors, defense attorneys, probation officers, and service providers can begin to develop plans for integration and utilization of substance abuse programs within detention facilities as well as within the community, as alternatives to sentencing.

V. Preliminary Goals and Recommendations

Strategies include cross training of other departments at the Youth Guidance Center, between health care providers and sheriff's department, and between adult probation and substance abuse service providers.

Increase communication and coordination between the Department of Labor, Small Business Association, unions, employers, EAPs, and service providers to assure compliance with the federal Drug-Free Workplace Act.

Possible strategies include implementing a database of information regarding state and federal laws and regulations, education and prevention materials, and employee assistance programs; and incorporating the business community into a community prevention strategy.

Establish partnerships in joint projects to provide a continuum of care.

The criminal justice focus team identified the need to develop a procedure that assures probationers and parolees access to appropriate substance abuse treatment. The discussion included the following specific recommendations:

- Front-end assessment of adults for substance abuse treatment needs coordinated with communication to the Courts and community organizations.
- Conduct staff training with community-based organizations and the probation department to diagnose and refer substance abusers. Educate probation officers regarding programs available inside and outside of jails.
- Improve communication and networking between probation officers and service providers.

Another recommended joint project was to establish a "one-stop shopping" approach to service delivery as demonstrated by the Mayor's Homeless Project/Multi-service Centers. This would involve many departments and service providers to assure accessibility of services such as childcare, health care, and other social amenities not directly related to treatment.

A third joint project identified was to enhance the assessment of primary or secondary substance abuse of patients in hospitals. In San Francisco General Hospital, many of the patients are there because of substance abuse issues, yet they are often only treated for the primary diagnosis: broken bones, gunshot wound, injuries due to car accident, etc.

Finally, the recommendation for a centralized intake for all clients entering substance abuse treatment or those being transferred within the system would enhance case management and the continuity of care.

Goal II: To assure the involvement of interested participants from all of San Francisco's diverse communities in planning for substance abuse prevention and treatment services.

Community forums are essential to establishing priorities, designing and delivering substance abuse services. Creating strategies for empowering communities, establishing ownership and solidifying partnerships is the backbone of an effective Master Plan.

**V.
Preliminary
Goals
and
Recommendations**

Goal III: To establish a system that assures treatment on demand that is accessible to everyone.

Treatment on demand can be achieved successfully with a variety of strategies. Developing new programs, expanding existing ones, training across professional disciplines were the most commonly recommended by the focus teams and other planning groups. Specific recommendations included:

- Increase availability for a residential youth home for substance abusers ages 12-17.
- Establish a residential treatment program for Latino youth
- Increase treatment options for adolescents
- Increase residential treatment for HIV+ women, pregnant women, women with children, methadone clients, homeless, residential detox, psychotropic medication/ dual diagnosis, etc. HIV
- Increase the availability of alcohol and drug-free housing
- More publicly funded methadone slots
- More highly structured alcohol out-patient groups and individual treatment for men
- Expand acupuncture programs throughout S.F. County as an alternative to methadone and other addictive drugs or treatment modalities
- Increase prevention and treatment inside detention facilities
- Establish comprehensive services for IVDU's including a needle exchange program
- Adopt a new Model for providing services to persons with disabilities
- Development of comprehensive continuum of alcohol and drug services for adults, adolescents and children in the Mission District
- Designation of sober living environments
- Increase treatment for dually diagnosed, co-dependents, drug-exposed infants
- Develop pre-care treatment for those on waiting lists

V. Preliminary Goals and Recommendations

A general recommendation that applies to both treatment and prevention programs, is to investigate, expand and institutionalize alternative philosophies and model programs. In addition, new programs must be physically and programmatically accessible to the disabled community.

Enhance or modify existing treatment programs with innovative approaches to increase success in working with specific populations.

The Educational focus group recommended employing a wholistic approach to education which applies to treatment as stated by the following recommendations:

- Involve families in substance abuse treatment
- Determine the role that a case management approach can have in substance abuse treatment
- Short-term programs to satisfy court requirements
- Home delivery of methadone to seriously ill persons with AIDS.
- Access to clinical trials for HIV+ persons.
- More attention should be given to the medically compromised, disabled, dementia affected HIV-infected population, treatment

- for HIV+ families, HIV+ youth and stimulant detoxification
- Include partners and address co-dependency and family issues in treatment for lesbians and bisexuals. Provide services for children of lesbian and bisexual alcoholics/addicts.
- More support and recognition of the importance for nuclear/extended families by professionals. e.g.: grandparents who are rearing kids of addicted parents

Goal IV: To expand intervention programs for engaging people into treatment.

Intervention programs can prevent the need to respond to the crisis of alcoholism and addiction. The concern for early intervention was evident by the recommendations made particularly for high risk youth and HIV+ substance abuser. Specific recommendations are as follows:

- Substance abuse services in community day schools/alternative schools
- More youth-generated groups such as Friday Night Live, Peer Resource, and support groups for recovering students
- Reaching crack users of dealers especially in Sunnydale/Bayview-Hunter's Point housing projects and out of school youth
- Develop policy and procedure on drug testing of youth in custody or complete assessment of drug use linked with referral system
- Implement Project M-Power, an assessment and referral program for youth at the street level
- HIV/AIDS outreach services for current users who refuse to enter treatment. Implement models that focus on "harm reduction", i.e.: needle distribution, safe injection education, and on-site access to medical care at treatment centers and on the street by mobile units.
- Provide more comprehensive emotional support and crisis intervention services for HIV+ substance abusers during nighttime and weekend hours. Limited referrals are available now.

Goal V: To increase the availability and effectiveness of substance abuse prevention.

Community prevention strategies extend beyond individual education and skill development. The following recommendations are primarily in three categories: policy, community organizing, and community education through mass media campaigns.

- Increase opportunities for and incorporate vocational skills training into academic curriculum
- Have Youth Aware staff train elementary school teachers to do substance abuse education so that Youth Aware can devote time to support groups
- Employ a holistic health approach to substance abuse education
- Include alcohol use, abuse in all discussion regarding drugs and society
- Restrict, limit and possibly ban the use of billboards for advertising of alcohol and cigarettes in the Mission.

**V.
Preliminary
Goals
and
Recommendations**

V. Preliminary Goals and Recommendations

- Educate and recruit parents and encourage parent-involvement. A one day event that includes training and entertainment
- Involve the media more in the recognition of model programs and the dissemination of innovative prevention, education, and treatment strategies
- Comprehensive substance abuse prevention campaign, that would include the use of advertising mediums.
- Development of prevention and information resource booklet, highly produced, entitled "Guide to Preventing Substance Abuse" for residents and families.

Establish prevention services for youth to meet specific needs.

Specific recommendations include:

- Self-Help - Pre-adolescent programs etc. should be run in the schools, communities and churches.
- Services for out-of-school youth as well as services when school is not in session: Summer, Spring break, Monday - Friday 3-9 p.m.
- Additional training for teachers who work with youth who are classified as needing special education, for example, developmentally disabled, mentally retarded, drug exposed and Fetal Alcohol Syndrome (FAS) kids. Each school's curriculum should be written or revised to meet the needs of special education students.
- Increase alternatives for youth such as employment and recreation

Establish education and intervention services for adults and seniors.

Because prevention services are often designed for youth, nearly half of the population does not receive substance abuse education. Recommendations include the establishment of prescription drug education for seniors, education in the workplace, small business Employee Assistance Programs, and drug-free zones at fairs and in certain blocks of the area. In addition, the expansion and increased publicity and accessibility of general information and community educational series for persons curious about their own alcohol and drug use as well as that of others was recommended.

Goal VI: To improve the quality of services.

Recommendations ranged from training at the provider level to administrative changes and enforcement issues.

- Design and implement training to all substance abuse providers serving the general population to overcome a lack of sensitivity and openness to the needs of lesbians, gay men and bisexual clients. Required alcohol and other drug programs to keep statistics on the sexual orientation of their clients. Programs should receive technical assistance on developing sensitive methods to obtain this information
- Sensitivity to cultural and literacy differences. Implement training by corporations to examine general differences.
- Advocacy for HIV+ persons and substance abusers. Individual, as well as, community attitudes around alcohol and other drug abuse and addiction should be examined more closely.

- Assure the availability of materials in alternative formats (braille, audio tapes), services for people who are deaf (ASL interpreters, existence of TDD's), and a wheelchair lift-equipped van.
- Promote change in attitude among providers through cross training of substance abuse and disability professionals. Accommodate as many people rather than mere legal compliance.
- Assure compliance with Section 504 of the 1973 Rehabilitation Act within the substance abuse delivery system
- Set standards for quality of substance abuse treatment
- Establish a Division Level Substance Abuse Branch within the Health Department
- Train Healthcare workers in substance abuse

Establish outreach, prevention and treatment services for specific needs of target populations.

A number of populations were identified as being particularly in need of increased outreach, prevention and treatment services. These included the disabled community (including hearing and vision impaired), immigrants with language needs, lesbians-particularly lesbians of color, women with children pregnant teens and American Indians. In the Criminal Justice system, presentence programs need to be made more available for pregnant offenders; and people released from jails need increased access to treatment program with designated beds/slots and admission priority.

Goal VII: To increase revenues for a comprehensive substance abuse system.

Develop funding strategies to enhance the continuum of treatment.

In addition to the recommendations for expansion and new services, the following items were identified as requiring new funds:

- Pre-treatment components, family support and counseling, and housing for treatment program graduates and newly released prisoners, especially women with children
- EAP liaison position for CSAS to assist businesses in establishing policies and programs
- Educational materials for placement in treatment facilities, e.g.: 12 step recovery literature, information on insurance for health care and dental plans, condoms/safe sex information and bleach
- Continuation of successful demonstration projects and replication of the most appropriate ones into our schools and communities

Reexamine spending patterns and policies within and between departments.

To assure substance abuse funding is allocated to address the most critical needs, and to maximize the effectiveness of dollars spent, each department must reexamine spending patterns and policies. One recommendation was to divert money from jails and prisons into prevention, schools, drug-free after-care for kids. Redirect General Assistance funds so that all homeless with substance abuse problems are provided alcohol and drug treatment.

V. Preliminary Goals and Recommendations

Combine resources and expertise to develop collaborative grant proposals.

As more funding sources are recognizing the need to promote resource sharing and collaboration among services providers, consortiums, partnerships, and memorandums of understanding are built into requirements for funding. San Francisco has already been successful in establishing collaborative programs, and recommendations indicate the need to continue exploring and increasing collaborative grant opportunities by engaging in more coalition building, resource sharing and development of consortiums. Relationships should emphasize partnerships and cooperation. These values should be incorporated into agency contracts. Funding should be shared and accountability should be emphasized. The San Francisco Unified School District recommended determining if more funding is available through the Drug Free Zones Program. Currently, this program only targets specific schools. The State model recommends the establishment of a network of community providers who sponsor various services on campus.

Increase third party payments.

Third party payment and client fees are an untapped resource in many programs. The Department and treatment providers must work together to assure that substance abuse treatment is re-imbursable through Medi-cal and that Medi-cal slots are permanent. In addition, adequate insurance coverage must be available for appropriate substance abuse treatment, including meeting needs other than hospital care.

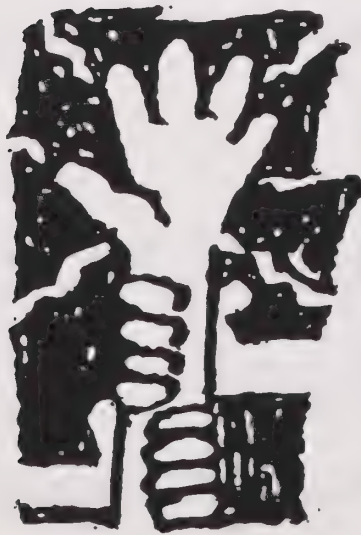
Develop creative packaging for appealing to funding sources.

Designing innovative programs either as demonstration projects or to meet a need that has been unfulfilled is yet another way to appeal to funding source. For example, present the jails as a high risk neighborhood (80% of the inmates are substance abusers) to fund and establish detention based substance abuse programs, as well as community based transition programs.

V. Preliminary Goals and Recommendations

**Join the San Francisco Drug Rebellion.
The solution is in our hands.**

VI.
Appendices



**SAN FRANCISCO
DRUG REBELLION**

**Health and Safety Code
Section 11998.1
County Master Plan Goals
Checklist**

The Department of Alcohol and Drug Programs (ADP) is required by Senate Bill (SB) 2599 to prepare an annual report to the Governor and the Legislature which includes a statement of the progress made towards achieving each goal specified in the legislation. To simplify this process, ADP has developed a checklist for counties to use in reporting their progress on achieving the specified goals.

County responses will be compiled to determine the number of counties that are addressing each goal. Progress made towards achieving the goals will not be reported by county. This information will be summarized for reporting purposes. Counties will have an opportunity to review a draft of the SB 2599 goal summary prior to its inclusion in the final report.

In completing the checklist, please answer "yes" if the goal is currently being addressed or will be addressed in the future. Please answer "no" if the goal is not currently being addressed and will not be addressed in the future. If the answer is "no", please provide a brief explanation in the "comments" section (e.g., not quantifiable, N/A for county, needs clarification, no data available, etc.).

A. The county master plan shall include, but not be limited to, all of the following parts:

(Y)N

(1) A part describing existing public services and activities provided by health, social, education, and criminal justice agencies and community organizations.

Comments:

(Y)N

(2) A part describing health, social, education, and criminal justice service needs of the county.

Comments:

(Y)N

(3) A part describing health, social, education, and criminal justice service need priorities, program objectives, and strategies for development and implementation of needed services.

Comments:

Will be further developed and refined in Year II.

(Y)N

(4) A part describing the county's progress in meeting the requirements of (1), (2), and (3) above.

Comments:

Will be further developed and refined in Year II.

(Y/N)

(5) A part describing the county's recommendations for improving the quality and effectiveness of federal, state, and local services within the health, social, education, and criminal justice service systems.

Comments:

Needs additional development, refinement in Year II.

(Y/N)

B. The county master plan shall be developed jointly by the county designated drug and alcohol administrators in consultation with the county Master Plan Advisory Body and approved by the county board of supervisors. For those counties in which the drug and alcohol programs are jointly administered, the administrator shall develop the county master plan. To the degree possible, all existing local plans relating to drug or alcohol abuse shall be incorporated into the county master plan.

Comments:

C. The membership of the advisory body shall be representative of the county's population and shall be geographically balanced. To the maximum extent possible, the advisory body shall include, as appropriate, agency and organization representatives with policy or executive authority, or their designees. To the maximum extent possible, membership shall include, but need not be limited to, all of the following:

(Y/N)

(1) Health services including, the treatment and recovery community and persons with expertise in AIDS treatment services.

Comments:

Need to recruit client representatives.

(Y/N)

(2) Social services including, public and private community organizations involved in drug and alcohol services.

Comments:

(Y/N)

(3) Education services, including parents and students.

Comments:

Need to recruit more youth/students.

(Y/N)

(4) Criminal Justice organizations including, law enforcement, probation and the judiciary.

Comments:

(Y/N)

(5) Other public and private community groups and organizations including, private industry and a representative of organized labor responsible for the provisions of Employee Assistance Program Services.

Comments:

Not achieved in Year I. New strategies for outreach and involvement will be developed and implemented in Year II.

D. Every county master plan shall include quantitative outcome objectives that, at a minimum, measure the progress of service strategies provided by the health, social, education, and criminal justice systems. These objectives shall include, but not be limited to, measurements of:

(Y/N)

(1) The reduction of arrests for driving under the influence of drugs or alcohol, or both.

Comments:

DUI arrest rates are less an indicator of progress in reducing substance abuse problems than a measure of law enforcement policies and activities.

(Y/N)

(2) The reduction of alcohol and drug-related arrests.

Comments:

See comment under D1 above.

(Y/N)

(3) Increased public education on the dangers of substance abuse and the available prevention techniques including specific measurements of children, parents, and teachers who have received this education.

Comments:

To be determined in Year II.

(Y/N)

(4) The reduction of alcohol and drug related deaths and injuries.

Comments:

To be developed in Year II.

(Y/N)

(5) The increased number of persons successfully completing drug and alcohol abuse services.

Comments:

Needs clarification: How is success defined? Completing treatment? Clean and sober one year? For what treatment modality?

(Y/N)

E. If a county master plan is adopted, the board of supervisors or its designees shall, in conjunction with the county advisory boards as established pursuant to Subdivision (c) of Section 1198.5, annually assess the progress of the county in reaching its long-range goals.

Comments:

F. With regard to education and prevention of drug and alcohol abuse programs, the following goals:

(Y/N)

(1) Drug and alcohol abuse education has been included within the mandatory curriculum in kindergarten and grades 1 to 12, inclusive, in every public school in California.

Comments:

Has not been determined by Education Focus Team or SF Unified School District, pending financial resources.

(Y/N)

(2) Basic training on how to recognize, and understand what to do about, drug and alcohol abuse has been provided to administrators and all teachers of kindergarten and grades 1 to 12, inclusive.

Comments:

See comment under F1 above.

(Y/N)

(3) All school counselors and school nurses have received comprehensive drug and alcohol abuse training.

Comments:

To be determined in Year II.

(Y/N)

(4) Every school board member has received basic drug and alcohol abuse information.

Comments:

To be determined in Year II.

(Y/N)

(5) The number of drug and alcohol abuse related incidents on school grounds has decreased by 20 percent.

Comments:

Data search did not turn up records on this information. Will require additional research.

G. With regard to community programs, the following goal:

(Y/N)

(1) Every community-based social service organization that receives state and local financial assistance has drug and alcohol abuse information available for clients.

Comments:

To be determined in Year II.

H. With regard to drug and alcohol abuse programs of the media, the following goals:

(1) The department on a statewide basis, and the county board of supervisors or its designees at the local level, have:

(Y/N)

(A) Assisted the entertainment industry in identifying ways to effectively use the entertainment industry to encourage lifestyles free of substance abuse.

Comments:

(Y/N)

(B) Assisted the manufacturers of drug and alcohol products in identifying ways to effectively use product advertising to discourage substance abuse.

Comments:

To be determined in Year II.

(Y/N)

(C) Assisted television stations in identifying ways to effectively use television programming to encourage lifestyles free of substance abuse.

Comments:

I. With regard to drug and alcohol abuse health care programs, the following goals:

(Y/N)

(1) The number of drug and alcohol abuse-related medical emergencies has decreased by 4 percent per year.

Comments:

Data not available for secondary admits. Primary emergency room admits due to overdose may be available. Requires additional research. Is also dependent on increased federal and state funding for intervention and treatment.

(Y/N)

(2) Sufficient drug and alcohol treatment and recovery services exist throughout the state to meet all clients' immediate and long-range needs.

Comments:

Ambitious, difficult to quantify. Is also dependent on increased federal and state funding.

(Y/N)

(3) All general acute care hospitals and AIDS medical service providers have provided information to their patients on drug and alcohol abuse.

Comments:

To be determined in Year II.

J. With regard to private sector drug and alcohol abuse programs, the following goals:

(Y/N)

(1) Noteworthy and publicly recognized figures and private industry have been encouraged to sponsor fund raising events for drug and alcohol abuse prevention.

Comments:

(Y/N)

(2) A significant percentage of businesses in the private sector have developed personnel policies that discourage drug and alcohol abuse, encourage supervision, training and employee education, and encourage treatment for those employees who require this assistance.

Comments:

To be determined to extent possible. Policies are less prevalent in small business community.

K. With regard to private sector direct care service providers the following goals:

(Y/N)

(1) Adequate nonresidential and residential services are available statewide for juveniles in need of alcohol or drug abuse services.

Comments:

A major barrier is working with health insurance companies. Requires additional federal and state funding.

(Y/N)

(2) Drug and alcohol abuse treatment providers provide general information about acquired immune deficiency syndrome (AIDS) during treatment.

Comments:

L. With regard to education and prevention of drug and alcohol abuse programs, the following goals:

(Y/N)

(1) Each public school district with kindergarten and grades 1 to 12, inclusive, has appointed a drug and alcohol abuse advisory team of school administrators, teachers, counselors, students, parents, community representatives, and health care professionals, all of whom have expertise in drug and alcohol abuse prevention. The team coordinates with and receives consultation from the county alcohol and drug program administrators.

Comments:

To be determined in Year II.

(Y/N)

(2) Each school district has a drug and alcohol abuse specialist to assist the individual schools.

Comments:

To be determined in Year II.

(Y/N)

(3) Each school in grades 7 to 12, inclusive, has student peer group drug and alcohol abuse programs.

Comments:

(Y/N)

(4) Every school district with kindergarten and grades 1 to 12, inclusive, has updated written drug and alcohol abuse policies and procedures including disciplinary procedures which will be given to every school employee, every student, and every parent.

Comments:

(Y/N)

(5) Every school district with kindergarten and grades 1 to 12, inclusive, has an established parent teachers group with drug and alcohol abuse prevention goals.

Comments:

Needs clarification: one PTA per school district or school?

(Y/N)

(6) Every school district has instituted a drug and alcohol abuse education program for parents.

Comments:

To be determined in Year II.

(Y/N)

(7) Every school district has established a parent support group.

Comments:

(Y/N)

(8) Every school district has instituted policies which address the special needs of children who have been rehabilitated for drug or alcohol abuse problems and who are reentering school. These policies shall consider the loss of schooltime, the loss of academic credits, and the sociological problems associated with drug and alcohol abuse, its rehabilitation, and the educational delay it causes.

Comments:

To be determined in Year II.

M. With regard to community programs, the following goals:

(Y/N)

(1) All neighborhood watch, business watch, and community conflict resolution programs have included drug and alcohol abuse prevention efforts.

Comments:

To be determined in Year II.

(Y/N)

(2) All community-based programs that serve schoolage children have staff trained in drug and alcohol abuse and give a clear, drug- and alcohol-free message.

Comments:

To be determined in Year II.

N. With regard to local government drug and alcohol abuse programs, the following goals:

(Y/N)

(1) Every county public social service agency has established policies that discourage drug and alcohol abuse and encourage treatment and recovery services when necessary.

Comments:

(Y/N)

(2) Every local unit of government has an employee assistance program that addresses drug and alcohol abuse problems.

Comments:

(Y/N)

(3) Every local unit of government has considered the potential for drug and alcohol abuse problems when developing zoning ordinances and issuing conditional use permits.

Comments:

To be determined in Year II.

(Y/N)

(4) Every county master plan includes treatment and recovery services. The plan shall include treatment and recovery services for juvenile offenders on probation and juvenile offenders committed to ranches.

Comments:

(Y/N)

(5) Every county master plan includes specialized provisions to ensure optimum alcohol and drug abuse service delivery for handicapped and disabled persons.

Comments:

(Y/N)

(6) Every local unit of government has been encouraged to establish an employee assistance program that includes the treatment of drug and alcohol abuse-related programs.

Comments:

(Y)N

(7) Every local governmental social service provider has established a referral system under which clients with drug and alcohol abuse problems can be referred for treatment.

Comments:

(Y)N

(8) Every county drug and alcohol abuse treatment or recovery program which serves women gives priority for services to pregnant women.

Comments:

However, we have specific programs for pregnant addicts/alcoholics.

(Y)N

(9) Every alcohol and drug abuse program provides acquired immune deficiency syndrome (AIDS) information to all program participants.

Comments:

O. With regard to private sector direct service providers, the following goals:

(Y)N

(1) Drinking drivers programs have provided clear measurements of successful completion of the program to the courts for each court-ordered client.

Comments:

(Y)N

(2) All drug and alcohol abuse treatment programs provide poly drug abuse services or have an established referral system to ensure clients receive all needed services.

Comments:

(Y)N

(3) Each county to the extent possible provides localized alcohol and drug treatment and recovery services designed for individuals seeking assistance for polydrug abuse.

Comments:

P. With regard to supply regulation and reduction in conjunction with drug and alcohol abuse, the following goals:

(Y/N)

(1) Each county has a drug and alcohol abuse enforcement team, designated by the board of supervisors. This team includes all components of the criminal justice system. This team shall be responsible to the board of supervisors, shall advise the drug and alcohol abuse advisory board and the county on all criminal justice matters relating to drug and alcohol abuse, and shall advise the county alcohol and drug programs administrators regarding the development of the county master plan.

Comments:

To be determined in Year II.

(Y/N)

(2) Counties with more than 10 superior court judgeships have established programs under which drug cases receive swift prosecution by well-trained prosecutors before judges who are experienced in the handling of drug cases.

Comments:

To be addressed in Year II.

(Y/N)

(3) The courts, when determining bail eligibility and the amount of bail for persons suspected of a crime involving a controlled substance, shall consider the quantity of the substance involved when measuring the danger to society if the suspect is released.

Comments:

To be addressed in Year II.

(Y/N)

(4) Juvenile halls and jails provide clients with information on drug and alcohol abuse.

Comments:

(Y/N)

(5) Judges have been encouraged to include drug and alcohol abuse treatment and prevention services in sentences for all offenders. Judges are requiring, as a condition of sentencing, drug and alcohol abuse education and treatment services for all persons convicted of driving under the influence of alcohol or drugs.

Comments:

(Y/N)

(6) Each local law enforcement agency has developed, with the schools, protocol on responding to school drug and alcohol abuse problems.

Comments:

To be addressed in Year II.

Y/N

(7) Every county has instituted a mandatory driving while under the influence presentence offender evaluation program.

Comments:

To be determined in Year II.

Additional comments may be included below and on the reverse side of this page. Please indicate the page number, letter and corresponding number for each goal.



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